20/20 EyeCare, Inc.

Medical History Questionnaire

(Please Print)

Name: _____ **Today's Date:** _____

Address: _____ **Phone:** _____

City: _____ **State:**____ **ZIP**_____ **Work Phone:** _____

SSN#: _____/_____/_____**Birth Date:** ___/___/___ **M / F** **Employer:** _____

Occupation: _____

Name of Medical Doctor: _____

Referred by: _____

paper/radio/friend/relative/other

Last Medical Exam: ___/____/____

Emergency Contact: _____ **Parents (if minor):** _____

Relation: _____ **#:** _____ **#:** _____

E-mail: _____ **Last Eye Exam:** ____/____/____

Race (circle): Native American Asian Hispanic African American Caucasian

Ethnicity (circle): Hispanic/Latino Hawaiian/Other Non Hispanic or Latino

Medical History

Do you have any allergies to medications? □ no □ yes If yes, list: _____

_____

List any medications you take **(including oral contraceptives, aspirin, over the counter medication and home remedies):**

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Are you pregnant and/or nursing? □ no □ yes □ na

Do you wear glasses? □ no □ yes If yes, how old is your present pair of lenses? _____

Do you wear contacts? □ no □ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Disposable Are they comfortable? □ no □ yes

Family History

Please note any family history (***self, parents, grandparents: paternal or maternal, siblings, children***) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataracts	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other_____	□	□	□	_____

Please turn this over and complete side two