

Today's Date ____/____/____

Medical History Questionnaire

Please complete the **BOTH SIDES** of this questionnaire to help your doctor determine your risk for eye health problems and help you see better. All information is kept strictly confidential.

Name _____ Date of Birth ____/____/____

Occupation _____

Last Eye Exam (if with other doctor) (Mo)____/(Yr)_____ with Dr. _____

Are you allergic to any medications? ___Yes ___No If yes, what? _____

What **medications** do you currently take (including aspirin, oral contraceptives, over the counter medications and eye drops)? _____

What major injuries and surgeries have you had (including eye injury and surgery)?

If female, are you pregnant or nursing? ___Yes ___No

Do you have prescription glasses? ___Yes ___No If yes, how old are your present lenses? _____

Do you wear contact lenses? ___Yes ___No If yes, how old are your present lenses? _____

If yes, do you sleep in your contact lenses? ___Yes ___No

If you do not currently wear contact lenses, are you interested in wearing contact lenses? ___Yes ___No

Are you interested in refractive surgery (LASIK)? ___Yes ___No

Do you use tobacco products? ___Yes ___No

If yes, how many packs per day? _____ How many years have you been smoking? _____

Family History

Do any of your blood relatives (parents, grandparents, or siblings, living or deceased) have the following:
Please mark "yes" or "no" for each condition. (*Please do not include yourself or your children.*)

<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Unknown</u>	<u>If yes, then relationship to you</u>
Blindness	___	___	___	_____
Crossed Eyes/Lazy Eye	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment	___	___	___	_____
Retinal Disease	___	___	___	_____

→→ Please turn form over and complete side two ←←

Your Medical History

Please check "yes" or "no" for each condition.

Do YOU now have or in the past have you had any of the following?

EYES

- Crossed or Turned Eyes
- Lazy Eye
- Glaucoma
- Retinal Detachment
- Retinal Disease
- Cataracts
- Eye Surgery

YES	NO

MUSCULOSKELETAL

- Rheumatoid Arthritis

--	--

NEUROLOGICAL

- Multiple Sclerosis
- Headaches
- Migraines
- Seizures

ENDOCRINE

- Hypothyroidism (low thyroid)
- Grave's Disease
- Diabetes

EARS, NOSE, MOUTH, THROAT

- Sinus Problems
- Dry Throat/Mouth

RESPIRATORY

- Asthma
- Emphysema/COPD
- Tuberculosis

ALLERGIC/IMMUNOLOGIC

- Hay Fever/Allergies
- Lupus
- HIV/AIDS

YES	NO

CARDIOVASCULAR

- Heart Attack
- Other Heart Problems
- High Blood Pressure
- Stroke
- Circulatory Problems

GASTROINTESTINAL

- Intestinal/Bowel Problems

--	--

GENITOURINARY

- Kidney Disease
- Hepatitis
- Syphilis

SKIN

- Skin Cancer
- Skin Condition

HEMATOLOGICAL/LYMPHATIC

- Anemia
- Bleeding Problems
- Cancer

PSYCHIATRIC

- Depression
- Anxiety
- Mental Illness

Please list any other medical conditions that you have:



Thank you!
Please return completed forms to receptionist.