

## Medical History Questionnaire

This form is critical for the doctor to thoroughly evaluate your vision and health.  
Please completely fill out both sides. Thank you!

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Personal Medical History

Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Family Physician: \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations: \_\_\_\_\_

Are you currently being treated for any of the following?

Diabetes	Y / N	Heart Disease	Y / N	Stroke	Y / N
High Blood Pressure	Y / N	Arthritis	Y / N	Other	_____

List any medications you are currently taking (include oral contraceptives, aspirin, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Do you have allergies to medications? Y / N If yes, please list: \_\_\_\_\_  
If female, are you currently pregnant? Y / N

### Eye History

#### Disease/Condition

Glaucoma	Y / N
Macular Degeneration	Y / N
Cataracts	Y / N
Retinal Tear/Detachment	Y / N
Foreign Body Sensation	Y / N
Eye Pain	Y / N
Blurred Vision	Y / N
Decreased Vision	Y / N
Double Vision	Y / N
Flashes of light	Y / N
Floating dark spots	Y / N
Past Eye Surgeries?	Y / N
Past Eye Injuries?	Y / N

#### Disease/Condition

Halos	Y / N
Light Sensitivity	Y / N
Redness	Y / N
Itching	Y / N
Burning	Y / N
Dryness	Y / N
Sandy/gritty feeling	Y / N
Lazy Eye	Y / N
Discharge	Y / N
Crusting on Eyelid	Y / N
Drooping Eyelid	Y / N

Type: \_\_\_\_\_ Date: \_\_\_\_\_  
Type: \_\_\_\_\_ Date: \_\_\_\_\_  
Other: \_\_\_\_\_

Do you currently wear glasses? Y / N Contact lenses? Y / N Neither

### Family Medical History

#### Relative

<u>Relative</u>	<u>Age</u>	<u>Eye/Medical Disease</u>
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Children	_____	_____
Other	_____	_____

### Social History

Marital Status Circle one: Single Married Separated Divorced Widowed  
Do you smoke? Y / N If yes, type/amount per week: \_\_\_\_\_  
Do you drink alcohol? Y / N If yes, type/amount per week: \_\_\_\_\_

