MEDICAL QUESTIONAIRE

Today's Date _____

Last _____

First _____ MI _____

Date of Birth _____ Age _____

Sex M or F

What is the purpose of this visit?

_____

_____

_____

Any problems with your current glasses or contact lenses?

_____

_____

Eye Health History

Date of Last Eye Exam_____

Do you…… (check box if your answer is yes)

❑..work at a computer?
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on LASIK?
❑..have more than 1 pair of current Rx eyewear?

If you wear bifocals, do the lines or head tilting bother you?
❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

If so, what kind/brand?_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Other eye disorders_____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)
(List names; include eye drops and vitamins) _____

_____

_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco or alcohol?
❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive/Gastric	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Immune	❑	❑
Integumentary (skin disease)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological/Headaches	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Stroke/Seizures	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Is there a family medical history of any of the following:
❑ No ❑ Yes
(if yes, state Mother/Father's side relationship)

Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____