MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Male ___ Female ____ Birth Date: ____ /____ /______

Address: ____ Social Security: ________ /________ /_________

City/State/Zip Code: ____

Phone: Home _______________________ Cell _______________________ Are you a full-time student? Yes ___ No ___

E-mail address: ____ Race/Ethnicity: ____________________________

Med Insurance/Supplement/Vision Plan: ____

Employer/Occupation: ___________________________________ Full time / Part time

Marital Status: ________________________ Parent/Guardian or Spouse: ___________________________________

MEDICAL HISTORY

Name of Medical Doctor: ______________________________ Phone: ____________________ Last exam _____ / _____

Preferred Pharmacy Name: ______________________________________ Address: ____________________________

Do you have any allergies to medications? Yes______ No ______ If yes, list : ___________________________________

____

List any medications you take regularly (including oral contraceptives, aspirin, OTC medications, and home remedies):

____

____

List any recent hospitalizations or major injuries: ____

Are you currently pregnant and/or nursing? Yes ____ No____

SOCIAL HISTORY

☐ I would prefer to discuss my Social History information directly with my doctor.

Do you drive? Yes _____ no _____ If yes, do you have visual difficulty when driving? Yes _____ no ______

Do you use tobacco products? Yes _____ no _____ If yes, type/quantity/duration: ___________________________________

Do you drink alcohol? No _____ Social use only _____ Moderate use _____ Heavy use _____

Do you use narcotics? Yes _____ no _____ If yes, type/quantity/duration: ____________________________________

Exposed to/infected with an STD? Yes _____ no _____ If yes, please specify: _________________________________

VISION MATERIALS HISTORY

Do you wear glasses? Yes ______ no ______ If yes, how old are your present lenses? ______________________________

Do you wear sunglasses? Yes _____ no _____ Protect against U/V? Yes _____ no _____ Polarized? Yes _____ no _____

Do you wear contact lenses? Yes ______ no ______ If yes, what type? Rigid _____ Soft _____ Comfortable? Yes _____ no _____

FAMILY HISTORY

CONDITION/DISEASE	YES	NO	UNKNOWN	SELF	OTHER
Crossed eyes	____	____	____	____	______________________
Lazy eye	____	____	____	____	______________________
Drooping eyelid	____	____	____	____	______________________
Blindness	____	____	____	____	______________________
Cataract	____	____	____	____	______________________
Glaucoma	____	____	____	____	______________________
Macular Degeneration	____	____	____	____	______________________
Retinal Detachment	____	____	____	____	______________________

PERSONAL HISTORY

CONDITION/DISEASE	YES	NO	UNKNOWN	CONDITION/DISEASE	YES	NO	UNKNOWN
Arthritis	____	____	____	Blurred Vision	____	____	____
Cancer	____	____	____	Glare/Light sensitivity	____	____	____
COPD	____	____	____	Distorted Vision/Halos	____	____	____
Diabetes	____	____	____	Loss of Side Vision	____	____	____
Heart Disease	____	____	____	Double Vision	____	____	____
High Blood Pressure	____	____	____	Eye Pain or Soreness	____	____	____
Vascular Disease	____	____	____	Mucous Discharge	____	____	____
Kidney Disease	____	____	____	Red eyes	____	____	____
Lupus	____	____	____	Flashes/Floaters in vision	____	____	____
Seasonal Allergies	____	____	____	Styes or Chalazion	____	____	____
Thyroid Disease	____	____	____	Chronic infection of eye or lid	____	____	____
Headaches	____	____	____	Foreign Body Sensation	____	____	____
Migraines	____	____	____	Excess Tearing/Watering	____	____	____