# Medical History Questionnaire

Full Name: ______________________________ Date of Birth ______________ Today's Date ______________

Name of your Primary Care Physician ______________________________ Year last seen ____________

Do you currently wear glasses? YES / NO Are you interested in glasses today? YES / NO

Do you currently wear contacts? YES / NO Are you interested in contacts today? YES / NO

## Medications

List any medications you take, prescription or over the counter: ____________________________________________

______________________________________________________________________________________________

List any known allergies to medications ______________________________________________________________

## Personal and Family History

Please note anyone (self, parents, grandparents, siblings) for the following conditions.

| Disease/Condition | Self | Mother | Father | Grandparent | Sibling |
|---|---|---|---|---|---|
| Allergies | | | | | |
| Arthritis | | | | | |
| Blindness | | | | | |
| Cancer | | | | | |
| Cataract | | | | | |
| Diabetes | | | | | |
| Glaucoma | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| Kidney Disease | | | | | |
| Macular Degeneration | | | | | |
| Nerve Disorder | | | | | |
| Retinal Detachment / Disease | | | | | |

Other ________________________________________________________________________________

Have you ever been exposed to or infected with: Hepatitis YES / NO HIV YES / NO

## Social History

Does your vision limit any daily activities (driving, reading, work, sports, etc.)? YES / NO

If yes, please explain: ________________________________________________________________________

Do you work on a computer? YES / NO If so, how many hours per day? ______________________________

Please list any hobbies that you currently enjoy: ____________________________________________________

## Vision History

Do you have any of the following symptoms? Please circle any that apply to you.

Dryness Redness Itching Glare/Light Sensitivity Flashes/Floaters Tired Eyes

If you answered yes to any of the above or have an ocular condition that is not listed, please explain:

______________________________________________________________________________________________

______________________________________________________________________________________________