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:

_____

_____