

MEDICAL HISTORY QUESTIONNAIRE (PAGE 1 OF 3)

NAME _____ DATE _____ DATE OF LAST EYE EXAM _____

■ List any **MEDICATIONS** you currently take (Prescription and Over-the-Counter)

■ Do you have any **ALLERGIES** to any medications? If "YES" list the medications. YES NO

■ List all **MAJOR ILLNESSES** (Glaucoma, Diabetes, High Blood Pressure, Heart Attack, etc.) or **INJURIES** (Concussion, etc.)

■ List any **SURGERIES** you have had (Cataract, Tonsillectomy, Appendectomy, etc.)

■ Have you had any **EYE CONDITIONS?** (Cataracts, Retinal Disease, Pink Eye, Crossed Eye, etc.)

■ Do you currently wear **CONTACT LENSES?** If "YES," how long have you worn them? What type of contact lenses and brand of solution?

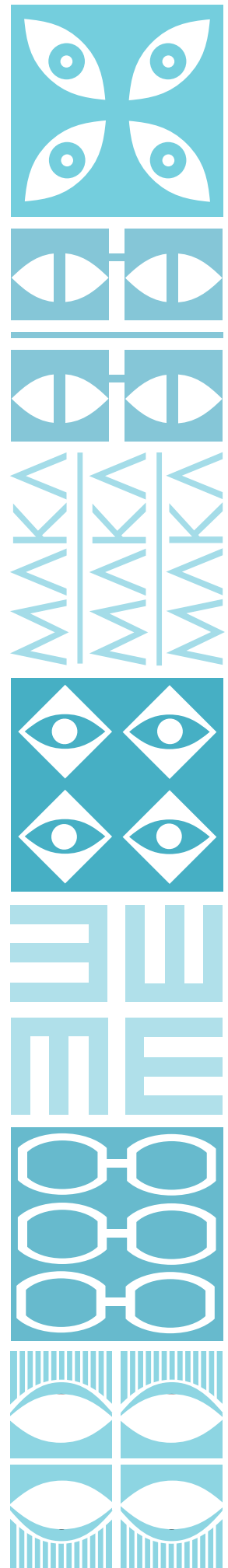
YES NO Year(s) Month(s) Type of Lens: Brand of Solution:

■ Do you wear **EYEGLASSES?** How long have you had the current prescription?

YES NO Year(s) Month(s)

■ Do you **CURRENTLY** have any problems in the following areas? If "YES," please provide information.

EYES	YES	NO	EXPLANATION OF CONDITION
GLAUCOMA, CATARACTS, RETINAL DISEASE			
LOSS OF VISION			
BLURRED VISION			
FLUCTUATING VISION			
DISTORTED VISION			
LOSS OF SIDE VISION			
DRYNESS			
MUCOUS DISCHARGE			



MEDICAL HISTORY QUESTIONNAIRE (PAGE 3 OF 3)

PLEASE INDICATE WHICH DISEASE APPLIES TO: M = Mother, F = Father, S = Sibling, G = Grandparent

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE OR HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LUPUS			
STROKE			
THYROID DISEASE			
OTHER			

SOCIAL HISTORY	YES	NO	EXPLANATION OF CONDITION
DO YOU DRIVE? If "YES," do you have visual difficulty when driving?			

