Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date:_____

Name:_____

Your age: _____

What is the main reason for your visit today?

_____

_____

What was the approximate date of your last eye examination: _____

Who did the exam? _____

How did you learn about our office?

Phone book Friend/Family Location

Other_____

Would you like to wear contact lenses?

Yes Not interested at this time.

Are you interested in LASIK?

Yes Not at this time.

Do you have any of these eye symptoms?

Blurred distance vision Glare, halos around lights

Blurred reading vision Itching Burning

Double vision Eye mattering Tearing

Flashing lights Floaters Foreign body sensation

Red Eyes Dry Eye Eye Pain

Have you ever had any of these eye problems?

Cataract Serious eye injury

Glaucoma Iritis/uveitis

Macular degeneration Lazy eye

Wore eye patch as a child Retinal detachment

Other:_____

Have members of your family had any eye diseases?

(This would be your father, mother, siblings, grandparents)

Glaucoma Diabetes Diabetic eye disease

Cataract Crossed eyes Blindness Poor Vision

Macular degeneration Retinal detachment

Iritis/uveitis Other:_____

Have you ever had any of these conditions?

Stroke Dizziness High blood pressure

Arthritis Allergies Heart disease Diabetes

AIDS, HIV Lung diseases Cancer Anemia

Thyroid disease Headaches

Other:_____

Are you pregnant or nursing?

No Yes

Do you have any allergies? (Medical or other)

None known If Yes, which ones? (list below)

Medication/material	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Which eye medications do you currently take?

None Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day

Which other medications do you currently take?

None Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day
_____	_____	1 2 3 4 6 per day

Do you use? Tobacco Alcohol

Please list any eye surgeries you have had:

None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any other surgeries you have had:

None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____