# Medical History Questionnaire

Name: _____ Date: ____/____/____

Birth Date: ____/____/____ Last Medical Exam ____/____/____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Dr.'s Phone _____

## Medical History

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? _____

Are you pregnant and/or nursing? ❑ No ❑ Yes

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair? _____

Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your present pair? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ No ❑ Yes

## Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions:

| DISEASE/CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|---|---|---|---|---|
| Blindness | ❑ | ❑ | ❑ | |
| Cataract | ❑ | ❑ | ❑ | |
| Crossed Eyes | ❑ | ❑ | ❑ | |
| Glaucoma | ❑ | ❑ | ❑ | |
| Macular Degeneration | ❑ | ❑ | ❑ | |
| Retinal Detachment/Disease | ❑ | ❑ | ❑ | |
| Arthritis | ❑ | ❑ | ❑ | |
| Cancer | ❑ | ❑ | ❑ | |
| Diabetes | ❑ | ❑ | ❑ | |
| Heart Disease | ❑ | ❑ | ❑ | |
| High Blood Pressure | ❑ | ❑ | ❑ | |
| Kidney Disease | ❑ | ❑ | ❑ | |
| Lupus | ❑ | ❑ | ❑ | |
| Thyroid Disease | ❑ | ❑ | ❑ | |
| Other _____ | ❑ | ❑ | ❑ | |

## Social History

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes If yes, please explain:

_____

Do you use tobacco products? ❑ No ❑ Yes If yes, type/amount/how long: _____

Do you drink alcohol? ❑ No ❑ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❑ No ❑ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis ❑ None

• Please turn this form over and complete side two •