Medical History Questionnaire

Name_____ Today's Date_____/_____/_____

Name of Medical Doctor_____ Last Medical Exam_____/_____/_____

Medical History:

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

_____

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

_____

_____

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

_____

List any eye infections or eye injuries that you have had:_____

_____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, other_____

Are you pregnant and/or nursing? ❑ no ❑ yes

Do you wear eyeglasses? ❑ no ❑ yes If yes, how old are your eyeglasses?_____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old are your lenses?_____

Type of contact lenses: ❑ rigid ❑ soft ❑ disposable ❑ other_____

Family History:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following 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_____	❑	❑	❑	_____

Names and ages of other family members living at home:

Husband/Dad_____ Wife/Mother_____

Sons/Brothers:_____ age_____ Daughters/Sisters_____ age_____

_____ age_____ _____ age_____

_____ age_____ _____ age_____