PATIENT INFORMATION

Patient First Name | Middle Initial | Patient Last Name

Address | City, State, Zip | Phone Number

Birthdate | Age | Marital Status Spouse Name | Parent/Guardian Name

Homephone | Cell Phone | Email | Social Security

Occupation | Employer

MEDICAL HISTORY QUESTIONNAIRE

Medical Doctor | Date of Last Medical Exam | Optometrist | Date of Last Eye Exam

Preferred Pharmacy | Town/City | Medication allergies? | If yes, please list.

Please list any medications that you take. (Name, dosage, times taken) Please include oral contraceptives, aspirins, or over the counter medications)

Please list all major injuries, surgeries, and/or hospitalizations you have had:

Have you had cataract surgery? Please list name of surgeon.

Pregnant or nursing? Yes:____ No:____

Do you wear glasses? Yes:____ No:____ (If yes, how old are your current lenses?)_____

Do you wear contact lenses? Yes:____ No:____ (If yes, what is the brand?) _____

Do you experience issues when wearing contact lenses? Yes:_____ (If yes, please explain) No:____

SOCIAL HISTORY

This information is kept confidential. However, you may choose to discuss this portion directly with the doctor if you prefer.

_____ Yes, I would like to discuss my social history information directly with my doctor.

Do you drive? Yes:____ No:____

If yes, do you have visual difficulty when driving? Yes:____ No:____

If yes, please explain: _____

Do you smoke or vape? Yes:____ (Please circle frequency: Daily, Occasionally, Former) No:____

Do you drink alcohol? Yes:____ No:____

Have you been exposed or infected with: Gonorrhea: _____ Hepatitis: _____ HIV: _____ Syphilis: _____