Medical History Questionnaire

Medical History

Are there any medications that you are allergic to? Yes No

If yes, explain or **attach list:**

List any medications you take (including prescriptions, oral contraceptives, vitamins, aspirin, over the counter medications, and home remedies) or **attach list:**

List any eye conditions/surgeries/diseases you have had (i.e. glaucoma, pinkeye, LASIK, etc) and when:

How did you hear about us? (i.e. Google, Yellow Pages, etc.)

Occupation : Employer:

Height: Weight:

PCP (Primary Care Physician):

Are you pregnant or nursing? Yes No

Do you use tobacco products? Yes No

If yes, type/amount:

Do you wear glasses? Yes No

If yes, how old is your current pair of lenses?

Do you wear contact lenses? Yes No

If yes, how old is your current pair of lenses?

Type of contact lenses: Rigid Soft Other

Are they comfortable? Yes No

Are you interested in contact lenses or needing to renew your contact lens prescription? (Additional contact lens exam fee will apply). Yes No

Are you interested in LASIK Yes No

Review of Systems (Ocular)

Have you noticed any change in your vision? Yes No Maybe

(i.e. trouble focusing, blurry vision, etc.)

Have you noticed any other issues with your eyes? Yes No Maybe

If yes, please explain:

Family History

Please note any family history for the following conditions:

Disease / Condition	**Yes**	**No**	**Relationship to you**
Diabetes			___________________
High Blood Pressure			___________________

Other

Family History (continued)

Disease / Condition	**Yes**	**No**	**Relationship to you**
Glaucoma			____________________
Macular Degeneration			____________________
Blindness			____________________
Cataracts			____________________
Other			____________________

Review of Systems (Systemic)

Please indicate in the following sections if **you** yourself have had any health issues (check box):

Vascular / Cardiovascular:	**Y**	**N**	**Not Sure**
High Blood Pressure			
Elevated Cholesterol			
Stroke			
Heart Disease			
Endocrine:			
Thyroid Disease			
Diabetes			
Gout			
Hypoglycemia			
Ear, Nose, Mouth, Throat:			
Seasonal Allergies			
Allergies (year-round)			
Headaches			
Migraines			
Bones / Joints / Muscles:			
Arthritis			
Muscle / Joint Pain			
Integumentary (skin):			
Skin cancer			
Lymphatic / Hematologic:			
Anemia			
Neurological:			
Seizures			
Nystagmus			
Dyslexia			
Respiratory:			
Asthma			
COPD			
Chronic Bronchitis			
Emphysema			
Psychiatric:			
Depression			
ADD / ADHD			
Autism / Asperger's			
Anxiety			

If you have any further medical conditions not specified above, or would like the doctor to be aware of any special circumstances, please list here:____________________________________