



Medical History Questionnaire

NAME _____ DATE _____

Personal Medical Information

Do you have any problems with any of the following systems? (please circle all that apply)

- | | | |
|--------------------------------------|-----------------------------------|-----------------------------------|
| Gastrointestinal | Neurological (Multiple Sclerosis) | Psychiatric (depression, anxiety) |
| Ears/Nose/Throat | Genitourinary | Endocrine (diabetes, thyroid) |
| Cardiovascular (high blood pressure) | Muscles/bones/joints | Blood/Lymph |
| Respiratory (asthma) | Integumentary (skin) | Are you Pregnant/Nursing? |

Provide more explanation/other Illnesses or Injuries: _____

Past Surgeries: _____

Diabetes? Y / N Type _____ Last A1C? _____ Date of diagnosis _____

Allergies? Y / N Allergic to What? _____ What happens? _____

Medication Allergy? Y / N Which Meds? _____

Do you smoke? Y / N Drink alcohol? Y / N Recreational/Illicit drugs? Y / N

Name of Family Doctor: _____ Address: _____

Date of last physical: _____

Current Medications/eyedrops: _____

Personal Eye Information

Last eye doctor seen? _____ Date? _____

Have you had any eye surgeries? Y / N Type: _____ Date: _____

Have you had eye injuries? Y / N Type: _____ Date: _____

With your glasses/contact lenses, are your eyes bothered by? (please circle all that apply):

- | | | | | | | |
|----------|------------------------|---------------|---------------------------------|---------|-------------------|---------|
| Sunlight | Night Glare | Dryness | Itching | Burning | Excessive Tearing | Flashes |
| Floaters | Foreign Body Sensation | Double Vision | Poor Reading or Distance Vision | | | |

Have you been told that you have: Cataracts? Y / N Glaucoma? Y / N Macular Degeneration? Y / N

Any other eye conditions (past or present)? _____

Do you wear glasses? Y / N Type (progressive, readers, trifocals, etc)? _____

Do you wear Contact Lenses? Y / N Brand: _____ How many hours/day? _____ Days/week? _____

Brand of lens cleaner? _____

Family History (please circle all that apply)

Hypertension Relation _____ Macular Degeneration Relation _____

Diabetes Relation _____ Retinal Detachment Relation _____

Thyroid Problems Relation _____ Cataracts Relation _____

Cancer Relation _____

Glaucoma Relation _____ Other Eye Conditions? _____

Do not write below this space

History Reviewed By: _____

Date Reviewed: _____

Orientation/Affect _____