MEDICAL HISTORY QUESTIONNAIRE

Patient's Name (Please Print) ____ Today's Date _____________

Birthdate: ___________ Marital Status: □ Divorced □ Legally Separated □ Married □ Single □ Widowed

Employer: ___________________________________ Occupation: __________________________________
If Student: School: ____________________________ Grade: _______________________________________

Racial Background: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Hispanic or Latino □ Native Hawaiian / Other Pacific Islander □ White/Caucasian

Name of Primary Care Physician ____

Are you interested in wearing Contact Lenses? □ Yes □ No Why? ______________________________

Are you interested in Laser Vision Correction (LASIK)? □ Yes □ No Why? _______________________

What is your primary reason for today's visit? ____

MEDICATIONS List any medications you are currently taking:

Systemic Medications (Prescribed) □ None	Systemic Medications (Over-the-Counter) □ None
_________________________	_________________________
_________________________	_________________________
_________________________	_________________________
_________________________	_________________________

Eye Medications/Drops (Prescribed) □ None	Eye Medications/Drops (Over-the-Counter) □ None
_________________________	_________________________
_________________________	_________________________

Do you have any allergies to medications? If yes, please list: ______________________________________

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Do you need a refill of your Eye Medications/Drops? If yes, please list: _____________________________

OCULAR SYMPTOMS Do you currently experience any of the following symptoms?

Symptom		Symptom	
Blurred Vision	□ Yes □ No	Eye Pain or Soreness	□ Yes □ No
Distorted Vision / Halos	□ Yes □ No	Redness	□ Yes □ No
Double Vision	□ Yes □ No	Itching	□ Yes □ No
Flashes of Light	□ Yes □ No	Burning / Dryness	□ Yes □ No
Floaters in Vision	□ Yes □ No	Sandy or Gritty Sensation	□ Yes □ No
Chronic Eyelid Inflammation	□ Yes □ No	Excess Tearing / Watering	□ Yes □ No
Stye or Chalazion	□ Yes □ No	Other: ______________________________	

This information is confidential and will be kept with your medical record and used only in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Thank you for assisting us in providing you with the very best eye health and vision care.

PERSONAL OCULAR HISTORY Have you ever had any of the following eye conditions?

Cataract	□ Yes □ No	Eye Injury	□ Yes □ No
Glaucoma	□ Yes □ No	Strabismus (Crossed Eyes)	□ Yes □ No
Macular Degeneration	□ Yes □ No	Other: ____________________	

PERSONAL OCULAR SURGERY HISTORY Have you ever had any of the following eye surgeries?

Cataract Surgery	□ Yes □ No	Retinal Detachment Surgery	□ Yes □ No
Glaucoma Surgery	□ Yes □ No	Eye Muscle Surgery	□ Yes □ No

Other: ____

PERSONAL MEDICAL HISTORY Have you ever had any of the following medical conditions?

Allergies	□ Yes □ No	Hypertension	□ Yes □ No
Arthritis	□ Yes □ No	Rosacea	□ Yes □ No
Asthma	□ Yes □ No	Seizure Disorder	□ Yes □ No
COPD	□ Yes □ No	Sleep Apnea	□ Yes □ No
Diabetes	□ Yes □ No	Stroke	□ Yes □ No
Elevated Cholesterol	□ Yes □ No	Thyroid Disorder	□ Yes □ No
Heart Disease	□ Yes □ No	Other: ____________________	

FAMILY HISTORY (Parents, grandparents, siblings, children)

Cardiovascular Disease	□ Yes □ No	Family Member(s): ____________________
Diabetes	□ Yes □ No	Family Member(s): ____________________
High Blood Pressure	□ Yes □ No	Family Member(s): ____________________
Cataract	□ Yes □ No	Family Member(s): ____________________
Glaucoma	□ Yes □ No	Family Member(s): ____________________
Macular Degeneration	□ Yes □ No	Family Member(s): ____________________

Other: ____

PERSONAL SOCIAL HISTORY (Age 13 and older)

Tobacco Use: □ Never smoked □ Former smoker □ Current smoker □ Current smokeless tobacco user

Do you use alcohol? □ Yes □ No □ Social use only

Do you use narcotics? □ Yes □ No

Have you had a sexually transmitted disease? □ Yes □ No

Have you had a blood transfusion? □ Yes □ No

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