

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

DATE: _____

Former eye doctor: _____

Current medical doctor: _____

Last eye exam: _____

Last medical exam: _____

MEDICAL HISTORY

Do you have any allergies to medications? Yes No If yes, explain: _____

List any medications you take (include oral contraceptives, aspirin, over the counter medications, and home remedies.)

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

Circle any of the following that **YOU** have had: crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: _____

Do you wear glasses?

Yes

No

Are you interested in learning more about
LASER VISION CORRECTION ?

Do you wear contact lenses?

Yes

No

Yes

No

Rigid

Extended wear

Soft

Frequent replacement

how often do you replace lenses? _____

Do you have a *family history* of any of the following?

Blindness

Cataract

Macular Degeneration

Crossed eyes

Glaucoma

Retinal detachment

Cancer

Retinal Disease

High Blood Pressure

Arthritis

Diabetes

Thyroid Disease

Heart Disease

Kidney Disease

Lupus

Do **YOU** currently have:

Headaches

Heart Disease

Rheumatoid Arthritis

Migraines

Vascular disease

Muscle pain

Seizures

High blood pressure

Joint Pain

Allergies/ Hay fever

Asthma

Syphilis/Gonorrhea

Dry Throat/Mouth

Chronic Bronchitis

Genital/kidney/bladder disease

Diabetes

Emphysema

Hepatitis

Thyroid disease

Fever, weight loss/gain

HIV

Are you pregnant and/or nursing?

Yes

No

Do you use tobacco products?

Yes

No

Do you drink alcohol?

Yes

No

(This information is kept strictly confidential. It will be released only with your authorization.)

Please list any special questions or concerns you would like to discuss with the doctors or staff: _____

