



Medical History Questionnaire

GT:	Y	N	M
CL:	Y	N	M

Name: _____ Birth Date: ___/___/___ Today's Date: _____

Currently wearing: Glasses Contact lenses

Last Eye Exam: _____

Last Eye Doctor: _____

Current Medical Dr.: _____

Last Medical Exam: _____

Medical History

Allergies to medications? Yes No If yes, please list/explain: _____

Please list all medications you are currently taking (including aspirin, contraceptives, over the counter medications, supplements):

Please list all major surgeries and/or hospitalizations:

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship to You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eye/lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Systemic Disease/Condition	Yes	No	Not Sure	Relationship to You
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you wish.

Yes, I would prefer to discuss my social history directly with the doctor (check box and complete side 2)

Do you drive? Yes No If yes, do you have any difficulty when driving? Yes No If yes, please describe: _____

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illicit/illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever had a blood transfusion? Yes No

Have you ever been exposed to or infected with any sexually transmitted disease(s)? Yes No

*** Please turn this form over and complete side two***