Medical History Questionnaire

Name: _____Today's Date: _____/_____/_____
Address: _____Phone: _____ _____ _____
_____Occupation:_____
Birth Date: _____/_____/_____Social Security #:_____/_____/_____
Name of Medical Doctor: _____Dr.'s Phone: _____
Last Eye Examination was on _____/_____/_____
Reason for today's visit?_____

Medical & Ocular History

Disease/Condition	You		Family	
Blindness	Yes	No	Yes	No
Cataract	Yes	No	Yes	No
Crossed Eyes	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
High Cholesterol	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No
Anxiety/Depression	Yes	No	Yes	No
Other:_____				

List all medications you take: _____

Do you have any allergies to medications? If yes, explain: _____

If you are a female, are you pregnant and/or nursing? Yes No

Review of Ocular Symptoms

Do you presently have:

Loss/Blurred vision	Yes	No
Double vision	Yes	No
Dryness	Yes	No
Sandy or Gritty Feeling	Yes	No
Itching/burning/redness/tearing	Yes	No
Eye Pain or Soreness	Yes	No
Flashes or Floaters in vision	Yes	No
Other: _____		