Medical History Questionnaire

Patient Name:_____ Sex: M / F Today's Date: _____/_____/_____

Mailing Address: _____ Phone: _____

City:_____ State: _____ Zip: _____ Occupation: _____

Birth Date: _____Age: _____ Social Security #: _____/_____/_____ Work Phone: _____

Email:_____ Cell Phone:_____

Name of Medical Doctor: _____

Responsible Party (if patient is a minor): _____ Relationship: _____
(Parent or Legal Guardian)
Mailing Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone:_____

Type of Medical Insurance: _____ Type of Vision Insurance: _____

Subscriber Name:_____ Subscriber D.O.B.:_____ Subscriber SS#:_____

Medical History:

Date of Last Eye Exam: _____/_____/_____
Do you have any allergies to medications? ☐ No ☐ Yes If yes, please list: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
_____
_____

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

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, macular degeneration, cataracts, eye infections or eye injury: _____

Are you pregnant or nursing?	☐ No	☐ Yes	
Do you wear glasses?	☐ No	☐ Yes	If so, how old is your present pair of lenses? _____
Do you wear contact lenses?	☐ No	☐ Yes	If so, how old is your present pair of lenses? _____
Type of contact lens:	☐ Rigid	☐ Soft	☐ Extended Wear ☐ Other
Are they comfortable?	☐ No	☐ Yes	

Family History:

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness/ Low vision	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Lupus	☐	☐	_____
Thyroid	☐	☐	_____
Other: _____	☐	☐	_____

Please turn this form over and complete side two*