



Medical History Questionnaire

Do you have any allergies to medications? [] no [] yes If yes, explain:
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

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

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

Are you pregnant and/or nursing? [] no [] yes
Do you wear glasses? [] no [] yes If yes, how old is your present pair of lenses?
Do you wear contact lenses? [] no [] yes If yes, how old is your present pair of lenses?
Type of contact lenses: [] Rigid [] Soft [] Extended Wear [] Other Are they comfortable? [] yes [] no

Family History

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

Table with 5 columns: DISEASE/CONDITION, NO, YES, ?, RELATIONSHIP TO YOU. Rows include Blindness, Cataract, Crossed Eyes, Glaucoma, Macular Degeneration, Retinal Detachment/Disease, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Thyroid Disease, Other.

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

[] Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)
Do you drive? [] no [] yes If yes, do you have visual difficulty when driving? [] no [] yes If yes, please describe:
Do you use tobacco products? [] no [] yes If yes, type/amount/how long:
Do you drink alcohol? [] no [] yes If yes, type/amount/how long:
Do you use illegal drugs? [] no [] yes If yes, type/amount/how long:
Have you ever been exposed to or infected with: [] Gonorrhea [] Hepatitis [] HIV [] Syphilis



Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL					Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Postnasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		RESPIRATORY		
EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		VASCULAR / CARDIOVASCULAR		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High B/P	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GASTROINTESTINAL		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GENITOURINARY		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		BONES / JOINTS / MUSCLES		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		LYMPHATIC / HEMATOLOGIC		
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE							
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctors Signature

Date