Your last yearly eye health examination was on __/__/__

Please make any necessary changes below:
Name Last: ________________________
First: _____________________________
Address: ___________________________
City____________ State _____ Zip _____

Medical History Questionnaire – Please Complete All Questions

Home Phone (___)___-____
Employer/School___________________ Occupation/Job Title_____________________
Employer/School Address____________________ Employer Phone (___) ____ - _____
Medical Insurance_______________________ Vision Insurance___________________
Physician__________________________ Pharmacy Used_________________________
SS # _______________ Birth Date ___/___/___ E-Mail Address___________________
Responsible Party For Minor Child____
List any medications currently taking ____
____
List any allergies to medications____
List any surgeries you have had (cataract, appendectomy, heart, etc…)______________
____
Date of last physical exam ___/___/___

Do you currently have any problems in the following areas? If yes, please provide details.

EYES	YES	NO	DETAILS
Loss of Vision (Blind Spots)			
Blurred Vision			
Changing focus from near to distance			
Seeing Spots, lines, flashes, halos			
Light Sensitivity (sunlight)			
Night Glare (Headlights)			
Loss of side vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Burning			
Itching			
Sandy or gritty feeling			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

(OVER)

GENERAL	YES	NO	DETAILS
Ear, Nose, Throat (stuffy nose, ear ache, cough, dry mouth)			
Cardiovascular (high BP, racing pulse, etc.)			
Neurological (numbness, headache, etc.)			
Endocrine (diabetes, thyroid, etc.)			
Allergic (sneezing, swelling, redness, itching, hives, etc.)			
Genital, Kidney, Bladder			
Muscle, Bone, Joints			
Skin			
Psychiatric			
Blood/Lymph			
General/Constitutional			
Gastrointestinal			

M = Mother F = Father GP = Grandparent S = Sibling

DISEASES	SELF	FAMILY MEMBER
Blindness		
Cataracts		
Macular Degeneration		
Glaucoma		
Cancer		
Diabetes		
Heart Disease		
Stroke		
Lupus		
Multiple Sclerosis		
Arthritis		

SOCIAL HISTORY

Marital Status (Married, Single, Divorced, Widowed) ___________________________________

Do you drive….. YES NO Do you have visual difficulties when driving……. YES NO

Have you ever tried contact lenses……….. YES NO

Do you currently wear contact lenses……. YES NO Brand Name_____________

If yes, how long _______

Do you wear protective sunglasses……… YES NO

Are you interested in Laser Surgery…….. YES NO

Are you interested in alternatives to laser surgery……. YES NO

Do you use a computer…………………. YES NO Hours/Day__________

Do you drink alcohol……………………. YES NO How often__________

Do you smoke………………………….. YES NO _____ Pack/day

Do you use drugs………………………. YES NO

A deposit is required on all materials before they are ordered with the balance due on delivery. We will bill a responsible parent for services and materials. However, balances unpaid within 30 days will become the responsibility of the parent accompanying the child to the office.

Physicians Signature_____________________________________ **Date** ____/____/____