Medical History Questionnaire

Last Name ______________ First ______________ Age ______ Parent Guardian ______________

Address ______________ Home Phone ______________ Cell ______________

City/Zip ______________ Email ______________ Best to Call ______________

Employer ______________ Occupation ______________ Work Phone ______________

Describe how you use your vision at work so we can make the best lens recommendations for you ______________

____

How many hours/day are you using a computer? ______________

What kind of hobbies, sports and other interests do you have? ______________

Your Personal History

	YES / NO		YES / NO		YES / NO
Do you wear glasses?	☐ ☐	Are you light sensitive?	☐ ☐	Do you smoke?	☐ ☐
Do you wear contacts?	☐ ☐	If so, do you sleep in contacts?	☐ ☐	... Swim in contacts?	☐ ☐

How often do you throw your contacts away (honestly): Replace Daily 2 Weeks 1 Month 1+ Months Yearly

Do you take any medications? ______ If so, please list them: ______________

____

____

Please check any conditions you <u>currently have</u> or <u>are being treated for</u>:

☐ Drug Allergy	☐ Environmental Allergy	☐ Rheumatoid Arthritis	☐ Heart Disease
☐ Hypertension	☐ Stroke	☐ Cancer	☐ Pregnant/Nursing
☐ Head Trauma	☐ Diabetes	☐ Thyroid	☐ Depression
☐ Multiple Sclerosis	☐ Epilepsy	☐ Headaches	☐ Asthma
☐ Emphysema	☐ Arthritis	☐ Retinal Detachment	☐ Glaucoma
☐ Burning or Watering	☐ Cataracts	☐ Macular Degeneration	☐ Lazy Eye
☐ Eye Infections	☐ Eye Injury	☐ Double Vision	☐ Anemia
☐ Leukemia	☐ HIV/AIDS	☐ Eczema	☐ Rosacea
☐ Psoriasis	☐ STD (Herpes, Chlamydia)	☐ MS	☐ (other)

Gastrointestinal ☐ ______________ **Ears, Nose, Throat Problems** ☐ ______________

Family History

Does any family member (parents, grandparents, siblings, children) currently have or had any of the following conditions? Please write the relationship to you.

☐ Glaucoma	☐ Macular Degeneration	☐ Diabetes	☐ Crossed Eyes
☐ Retinal Detachment/Disease	☐ Other: ______________		

To the best of my knowledge, the above information is correct.

______________ ______________

Patient's signature or Parent/Guardian Today's Date