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 currently have or are being treated for:

☐ 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