Medical History Questionnaire

Vision History

Are you having difficulties with your vision? **YES** **NO** If YES, then what type? Distance Intermediate Near

Other _____

Do you wear glasses? **YES** **NO** If yes, how old is your current pair of daily glasses? _____

How old are your prescription sunglasses? _____ Your backup glasses? _____

How many hours do you spend on the computer and/or any smart screen device? _____

Do you wear contact lenses? **YES** **NO** If yes, how old are your contacts? _____

Type of contact lenses you wear: **Gas Permeable** **Soft** **Extended Wear** **Disposable** **Overnight**

If you wear disposable lenses, how often do your replace them? _____

What solution do you use to clean your contact lenses with? _____

Please circle any of the following you have had:

Crossed Eyes Lazy Eye Droopy Eyelid Protruding Eye/s Glaucoma Retinal Disease

Cataracts Eye Infection Eye Injury Eye Surgery

Personal Medical History

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

_____

Do you have any allergies to medications? NO YES If yes, please list medication

_____

Please list all major injuries, surgeries and/or hospitalizations you have had _____

_____

Females, are you pregnant or nursing? NO YES

Please note any general medical history for the following conditions

			If yes, please specify
Respiratory problems (shortness of breath, cough)	NO	YES	_____
Chronic fatigue, fever, unexpected weight gain/loss	NO	YES	_____
Ear, nose or throat problems	NO	YES	_____
Skin conditions (rashes, dryness)	NO	YES	_____
Musculoskeletal problems (arthritis, muscle pain)	NO	YES	_____
Heart problems (disease, blood pressure, irregular beat)	NO	YES	_____
Cancer	NO	YES	_____
Diabetes	NO	YES	_____
High Cholesterol	NO	YES	_____
Kidney Disease	NO	YES	_____
Liver Disease	NO	YES	_____
Thyroid Disease	NO	YES	_____
Neurologic problems (numbness, paralysis, headache)	NO	YES	_____
Psychiatric problems (depression, anxiety)	NO	YES	_____

Other _____

Family History

Are there any medical or eye diseases that run in the family (heart disease, diabetes, cancer, glaucoma, macular degeneration)?

YES **NO** If yes, please specify _____

_____