Medical History Questionnaire

Name: ______________________________ Date: ______________

Address me as: ______________ Birth Date: (MM)______/(DD)______/(YY)______

Last Eye Exam: ______________ Last Doctor / Location: ______________

Last Medical Exam: ______________ Medical Doctor: ______________

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 dry or uncomfortable? ***No*** ***Yes***

Would you be interested in more information regarding any of the following? (Please Circle)

Ortho-K ***Laser Surgery*** ***Botox*** ***Color Contacts*** ***Sunglasses***

Medical History

Are you allergic to any medications? ***No*** ***Yes*** If yes, please list: ______________

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

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

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

Are you pregnant or nursing? ***No*** ***Yes***

Family History

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

DISEASE / CONDITION	NO	YES	???	RELATIONSHIP TO YOU
Blindness	___	___	___	______________
Cataract	___	___	___	______________
Crossed Eyes	___	___	___	______________
Glaucoma	___	___	___	______________
Macular Degeneration	___	___	___	______________
Retinal Detachment / Disease	___	___	___	______________
Arthritis	___	___	___	______________
Cancer	___	___	___	______________
Diabetes	___	___	___	______________
Heart Disease	___	___	___	______________
High Blood Pressure	___	___	___	______________
Kidney Disease	___	___	___	______________
Lupus	___	___	___	______________
Thyroid Disease	___	___	___	______________
Other ______________				______________

*****Please turn this form over and complete side two*****