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Medical History Questionnaire Name: _____ Date: _____

Reason for today's visit:

_____

Are you having any of the symptoms below:

Yes	No		Yes	No	
___	___	Blurred vision with glasses	___	___	Eye Pain R___ L___ How long?_____
___	___	Halos or glare	___	___	Abnormal sensitivity to light
___	___	Difficulty reading	___	___	Scratchy eyes
___	___	Difficulty reading street signs	___	___	Itchy eyes
___	___	Poor side vision	___	___	Mattering
___	___	Double vision	___	___	Crusting
___	___	Flashes in vision	___	___	Excessive tearing
___	___	Night blindness	___	___	Headaches Location:_____ How long?___

Other, please list:

Do **YOU PERSONALLY** have a history of any of the conditions listed below:

Yes	No		Yes	No		Yes	No	
___	___	Diabetes	___	___	Arthritis	___	___	Tuberculosis
___	___	Hypertension	___	___	Thyroid problems	___	___	Other stomach ailments
___	___	Heart disease	___	___	Breathing problems	___	___	Ulcers
___	___	Cancer Type:_____				___	___	Other _____

Please check if there is any **FAMILY** history of:

____Glaucoma ____Retina Disease ____ Other, please list:_____
____Cataracts ____Diabetes

List all medications you are currently taking, including over the counter medications:

What eye drops are you currently using?

Are you allergic to any medications? _____ If yes, please list:

Please list any previous eye surgeries or injuries to the eye:

Do you smoke? _____ How much and how long? _____
Do you drink alcohol? _____ Amount and frequency? _____
Are you pregnant? _____
Present visual correction:____Glasses: ____Bifocal ____Trifocal ____Reading
Contact lenses:____Rigid gas permeable ____Soft ____Disposable ____ Toric ____Bifocal
Are you pleased with your current prescription? ___ Yes ___ No

_____
Patient Signature