MEDICAL HISTORY QUESTIONNAIRE

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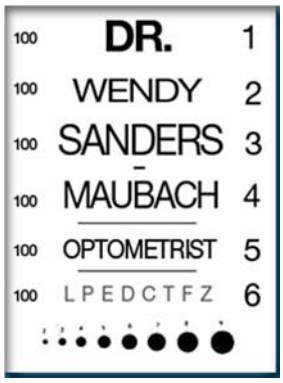

Name:		Date:	
Date of Birth:		Social	
Work Phone:		Home	
Home Address:			
City:			
State:		Zip:	
Guardian:			
Last Doctor's Exam:			

Medical History Information

Do you have any allergies to medication?	**NO**	Is yes,	

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

List all injuries, surgeries, and hospitalizations you have had:

List or Select any of the following you have had:				Eye injury information:	
crossed eyes	**lazy eye**	**dropping eyelid**	**glaucoma**	**retinal disease**	**cataracts**

Are you pregnant or nursing:		**YES**	**NO**	Do you wear glasses?		**YES**	**NO**
Do you wear contacts?		**YES**	**NO**				
How old are your contacts?		**YES**	**NO**				
Type of Contacts:	**Rigid**	**S**	**Hard**	**Extended Wear**	Are they comfortable?	**YES**	**NO**

Family History Information

Please note any family history (parents, grandparents, siblings, children, living or deceased)

Disease/ Condition	YES	NO	Relationship to you	Disease/	YES	NO	Relationship to you
Blindness	**YES**	**NO**		Cataracts	**YES**	**NO**	
Crossed Eyes	**YES**	**NO**		Glaucoma	**YES**	**NO**	
Macular Degeneration	**YES**	**NO**		Retinal Detachment/	**YES**	**NO**	
Arthritis	**YES**	**NO**		Cancer	**YES**	**NO**	
Diabetes	**YES**	**NO**		Heart Disease	**YES**	**NO**	
High Blood Pressure	**YES**	**NO**		Kidney	**YES**	**NO**	
Lupus	**YES**	**NO**		Thyroid	**YES**	**NO**	

*** Please fill out both pages of this form.**

Social History Information (This information is kept strictly confidential. However, you may discuss this directly with the doctor.)

YES	NO	I would prefer to discuss my Social History information with my doctor (select one).

Do you drive?	YES	NO	If yes, do you have a visual difficultly when driving?	YES	NO
If yes, please describe:					

Do you use tobacco products?	YES	NO	If yes, type/amount/how long?	
Do you drink alcohol?	YES	NO	If yes, type/amount/how long?	
Do you use illegal drugs?	YES	NO	If yes, type/amount/how long?	

Have you ever been exposed or infected with:	Gonorrhea	Hepatitis	HIV	Syphilis

Review of Systems (Do you currently, or have you ever had any problems in the following areas?)

System	YES	NO	?	System	YES	NO	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, Weight Loss/Gain	YES	NO	?	Allergies/Hay Fever	YES	NO	?
Integumentary (Skin)	YES	NO	?	Sinus Congestion	YES	NO	?
Neurological				Runny Nose	YES	NO	?
Headaches	YES	NO	?	Post-Nasal Drip	YES	NO	?
Migraines	YES	NO	?	Chronic Cough	YES	NO	?
Seizures	YES	NO	?	Dry Throat/Mouth	YES	NO	?
Eyes				**Respiratory**			
Loss of Vision	YES	NO	?	Asthma	YES	NO	?
Blurred Vision	YES	NO	?	Chronic Bronchitis	YES	NO	?
Distorted Vision/Halos	YES	NO	?	Emphysema	YES	NO	?
Loss of Side Vision	YES	NO	?	**Vascular / Cardiovascular**			
Double Vision	YES	NO	?	Diabetes	YES	NO	?
Dryness	YES	NO	?	Elevated Cholesterol	YES	NO	?
Mucous Discharge	YES	NO	?	High Blood Pressure	YES	NO	?
Redness	YES	NO	?	Vascular Disease	YES	NO	?
Sandy or Gritty Feeling	YES	NO	?	**Gastrointestinal**			
Itching	YES	NO	?	Diarrhea	YES	NO	?
Burning	YES	NO	?	Constipation	YES	NO	?
Foreign Body Sensation	YES	NO	?	**Genitourinary**			
Excess Tearing / Watering	YES	NO	?	Genitals/Kidney/Bladder	YES	NO	?
Glare / Light Sensitivity	YES	NO	?	**Bones / Joints / Muscles**			
Eye Pain or Soreness	YES	NO	?	Rheumatoid Arthritis	YES	NO	?
Chronic Infection of Eye or Lid	YES	NO	?	Muscle Pain	YES	NO	?
Sties or Chalazion	YES	NO	?	Joint Pain	YES	NO	?
Flashes / Floaters in Vision	YES	NO	?	**Lymphatic / Hematologic**			
Tired Eyes	YES	NO	?	Anemia	YES	NO	?
Endocrine				Bleeding Problems	YES	NO	?
Thyroid / Other Glands	YES	NO	?	**Allergic / Immunologic**	YES	NO	?
				Psychiatric	YES	NO	?

If you answered YES to any of the above or have a condition not listed, please explain & list medications.

Doctor's Signature

Date