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 glasses? ____________

How old are your prescription sunglasses? ____________

How old are your back up glasses? ____________

Do you spend any time on the computer? **YES NO** How long per day? ____________

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

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

If you wear disposable lenses, how often do you 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 explain
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 ____________________