Social History:

Do you drive?_____ No Yes

- If yes, do you have visual difficulty when driving? _____ No Yes
- If yes, please describe: _____

Do you use tobacco products? _____ No Yes

- If yes, type/amount/how long: _____

Do you drink alcohol? _____ No Yes

- If yes, type/amount/how long: _____

Do you use illegal drugs? _____ No Yes

- If yes, type/amount/how long: _____

Have you ever been exposed to or infected with Hepatitis?_____ No Yes

Have you ever been exposed to or infected with HIV? No Yes

Review of Systems: Are you currently having any problems in the following areas?

SYSTEM	No	Yes	?
CONSTITUTIONAL:			
Fever	❐	❐	❐
SKIN DISORDERS/RASH (Integumentary)**:**	❐	❐	❐
NEUROLOGICAL:			
Headaches/Migraines	❐	❐	❐
Seizures	❐	❐	❐
EYES:			
Loss of Vision	❐	❐	❐
Blurred Vision	❐	❐	❐
Distorted Vision/Halos	❐	❐	❐
Loss of Side Vision	❐	❐	❐
Double Vision	❐	❐	❐
Dryness	❐	❐	❐
Mucous Discharge	❐	❐	❐
Redness	❐	❐	❐
Sandy or Gritty Feeling	❐	❐	❐
Itching	❐	❐	❐
Burning	❐	❐	❐
Foreign Body Sensation	❐	❐	❐
Excess Tearing/Watering	❐	❐	❐
Glare/Light Sensitivity	❐	❐	❐
Eye Pain or Soreness	❐	❐	❐
Chronic Infection of Eye or Lid	❐	❐	❐
Styes or Chalazion	❐	❐	❐
Flashes/Floaters in Vision	❐	❐	❐
Tired Eyes	❐	❐	❐
ENDOCRINE:			
Thyroid/Other Glands	❐	❐	❐
Weight Loss/Gain	❐	❐	❐

	No	Yes	?
EAR, NOSE, MOUTH, THROAT:			
Sinus Congestion	❐	❐	❐
Runny Nose	❐	❐	❐
Chronic Cough	❐	❐	❐
Dry Throat/Mouth	❐	❐	❐
RESPIRATORY:			
Asthma	❐	❐	❐
Chronic Bronchitis	❐	❐	❐
Emphysema	❐	❐	❐
VASCULAR/CARDIOVASCULAR:			
Diabetes	❐	❐	❐
Heart Pain	❐	❐	❐
High Blood Pressure	❐	❐	❐
Vascular Disease	❐	❐	❐
Do you have a Pacemaker	❐	❐	❐
GASTROINTESTINAL:			
Diarrhea	❐	❐	❐
Constipation	❐	❐	❐
URINARY:			
Kidney/Bladder Disease	❐	❐	❐
BONES/JOINTS/MUSCLES:			
Rheumatoid Arthritis	❐	❐	❐
Muscle Pain	❐	❐	❐
Joint Pain	❐	❐	❐
LYMPHATIC/HEMATOLOGIC:			
Anemia	❐	❐	❐
Bleeding Problems	❐	❐	❐
ALLERGIC/IMMUNOLOGIC:			
Seasonal Allergies	❐	❐	❐
PSYCHIATRIC DISORDERS:			
Memory Loss/Depression	❐	❐	❐

If you have a condition not listed, please explain:_____

_____

Medical History Questionnaire

Name:		Mr. Mrs. Ms. Miss		Today's Date:
Mailing Address:		City/State/Zip Code:		
Birth Date:	Age:	Male Female	Home Phone: ( )	Work Phone: ( )
Occupation:	Employer:	Spouse or Parent:	Cell Phone: ( )	Email:
Last Eye Exam Date:		Vision Insurance and ID/Social Security Number:		
Last Medical Exam Date:	Name of M.D.	Medical Insurance:		

A minimum deposit of ½ of your account is payable when prescription eyeglasses or contact lenses are ordered. The balance is due on delivery of the prescription.

How will you settle your account today? Check Cash Credit Card We will only accept insurances and discounts at the time of the appointment.

Medical History:

Do you have allergies to medications? No Yes List: _____

List any medications you are taking (***including*** oral contraceptives, aspirin, over-the-counter medications, supplements, and home remedies):_____

_____

List all major injuries, surgeries, and/or hospitalizations: _____

_____

Circle any that ***you*** have had: crossed eyes lazy eye drooping eyelid prominent eyes dry eye
macular degeneration glaucoma retinal disease cataract surgery eye infections eye injury

Do you work at a computer for long periods? _____ No Yes

Do you have complaints about your glasses? _____ No Yes

Would you enjoy lenses that are thinner, lighter, and more comfortable? _____ No Yes

Are there times when you'd rather not wear contact lenses or glasses? _____ No Yes

Would you like information or a free evaluation regarding laser vision correction and your candidacy? No Yes

Do you wear contact lenses? *(If yes, complete prescription information is required to perform CL exam)* No Yes

Please list hobbies/interests: _____

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

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****