MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: ____/____/________

Patient Name: ______________________________ Family Doctor: ________________________

Date of Birth: ______/______/__________ Previous Eye Doctor(s): ______________________

Other Doctors you are seeing: ____

Are you here today for: ☐ a regular **Eye Health Exam**, ☐ a **Medical Issue** or ☐ **Information on LASIK**?

Please list ALL medications - prescription, over the counter **or** herbal - you currently take: ______________________

____

Known Drug Allergies:____

Do you have a Latex allergy?_________________________

Have you ever been advised against having refractive surgery? YES NO Why? ________________

Have You Ever Had:			**Are you currently experiencing:**		
Cataracts	YES	NO	Foreign body sensation	YES	NO
Glaucoma	YES	NO	Pain or soreness	YES	NO
Macular Degeneration	YES	NO	Sandy or gritty feeling	YES	NO
Retinal Detachment	YES	NO	Itchy Feeling	YES	NO
Loss of eye	YES	NO	Redness or Bloodshot	YES	NO
Laser Treatment (Type) ______________	YES	NO	Dry or burning feeling	YES	NO
Eye injury	YES	NO	Mucous discharge	YES	NO
Foreign body in eye	YES	NO	Lid swelling	YES	NO
Temporary vision loss	YES	NO	Blurred or distorted vision	YES	NO
Iritis	YES	NO	Glare of light sensitivity	YES	NO
Crossed/Wandering eyes	YES	NO	Fluctuating vision	YES	NO
Lazy eye or Amblyopia	YES	NO	Fatigue or tired eyes	YES	NO
Other:	YES	NO	Double Vision	YES	NO
Have you ever been treated for:					
High blood pressure	YES	NO	Thyroid condition	YES	NO
Heart disease	YES	NO	Arthritis or Lupus	YES	NO
Breathing problems	YES	NO	Skin ailments	YES	NO
Diabetes (how long?) ______________	YES	NO	Cancer (what kind) ______________	YES	NO
Circulatory problems	YES	NO	Tuberculosis	YES	NO
Stroke	YES	NO	Herpes/Shingles/Cold Sores	YES	NO
Headaches or Migraines	YES	NO	AIDS or HIV	YES	NO
Intestinal disease	YES	NO	Neurological or Emotional problems	YES	NO
Kidney or bladder disease	YES	NO	Drug or alcohol dependency	YES	NO
Liver disease or Hepatitis	YES	NO	Environmental allergies	YES	NO
Have you RECENTLY experienced:					
Pregnancy	YES	NO	Fever/Chills	YES	NO
Weight loss/gain	YES	NO	Chronic pain	YES	NO
Do you use tobacco products?	YES	NO	Do you drink alcoholic beverages?	YES	NO

Please circle any of the following conditions that run in your FAMILY

Glaucoma	Cataracts	Macular Degeneration	Blindness	Crossed/Lazy Eye	Corneal Disease
Diabetes	Thyroid Disease	Cancer	High Blood Pressure	Heart Disease	Strokes

Past surgical history: ____

Past serious illnesses: ____

Other conditions:____

To the best of my knowledge I have disclosed all health concerns. All other systems are normal.

Patient or Guardian Signature: ___________________________ Date:_______________