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 daily glasses? _____

How old are your prescription sunglasses?_____Your backup 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 your current pair of contacts? _____

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