Medical History Questionnaire

The Eye Group, S.C.

Name: _____

Birth Date: ____ /____ /____ (Month / Day / Year) Social Security#: _____ /_____ /_____ Today's Date: _____

Last Eye Doctor: _____ Last Eye Exam: _____ /_____ (Month / Year)

Current Medical Dr.: _____ Last Medical Exam: _____ /_____ (Month / Year)

Medical History

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

_____

_____

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

_____

Check any of the following that you have had: ❑ **Reading Difficulty** ❑ **Crossed Eyes** ❑ **Lazy Eye** ❑ **Glaucoma** ❑ **Retinal Disease** ❑ **Cataracts** ❑ **Eye Injury**

Are you pregnant and/or nursing? ❑ Yes ❑ No

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of glasses? _____

How many pair of glasses do you currently use? _____

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair of contacts? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ Yes ❑ No

Have you had refractive surgery? ❑ Yes ❑ No

At work: Do you perform fine or close-up work? ❑ Yes ❑ No

Are you outdoors all or part of the time? ❑ Yes ❑ No

Is safety protection a concern at work? ❑ Yes ❑ No

Do you have trouble reading signs when driving at night? ❑ Yes ❑ No

Are you bothered by the glare from: Overhead lighting? ❑ Yes ❑ No

A computer screen? ❑ Yes ❑ No

Oncoming headlights at night? ❑ Yes ❑ No

Are you sensitive in bright sunlight? ❑ Yes ❑ No

What hobbies or recreational sports do you enjoy? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition	**Yes**	**No**	**Not Sure**	**Relationship To You**
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Systemic Disease / Condition				
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other _____	❑	❑	❑	

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and complete Side 2