

MEDICAL HISTORY AND LIFESTYLE QUESTIONNAIRE

Date: _____

Patient Name: _____

Describe in your own words why you are seeing us today:

Please list all major injuries, surgeries, or hospitalizations

Please circle (Y) Yes, if you have the following. Or (N) No, if you do not. Please circle (F) Family if a family member does. If family member, please list relationship.

EYE HISTORY		Relationship
Glaucoma	Y / N / F	_____
Cataracts	Y / N / F	_____
Macular Degeneration	Y / N / F	_____
Injury / Surgery	Y / N / F	_____
Retinal Disease	Y / N / F	_____
Blindness	Y / N / F	_____
Eye Turn	Y / N / F	_____
Lazy Eye	Y / N / F	_____
Diabetic Eye Disease	Y / N / F	_____
Dry Eye	Y / N / F	_____

MEDICAL HISTORY

Unusual Weight Gain / Loss	Y / N / F	_____
Sleep Problems	Y / N / F	_____
Fatigue / Weakness	Y / N / F	_____
Heart Condition	Y / N / F	_____
High Blood Pressure	Y / N / F	_____
High Cholesterol	Y / N / F	_____
Ear / Nose / Throat Problems	Y / N / F	_____
Breathing Condition	Y / N / F	_____
Lung Condition	Y / N / F	_____
Stomach / Intestinal	Y / N / F	_____
Genitourinary	Y / N / F	_____
Muscle / Bone / Arthritis	Y / N / F	_____
Skin Rashes	Y / N / F	_____
Skin Cancer	Y / N / F	_____
Neurological	Y / N / F	_____
Headaches	Y / N / F	_____
Anxiety / Depression	Y / N / F	_____
Psychiatric Diagnosis	Y / N / F	_____
Endocrine	Y / N / F	_____
Diabetes	Y / N / F	_____
Thyroid	Y / N / F	_____
Blood / Lymph Disorders	Y / N / F	_____
Allergies	Y / N / F	_____
Cancer	Y / N / F	_____
Other	Y / N / F	_____

Please attach or list current medications.

(Prescribed or over the counter) _____

Allergies to Medicines _____

Do you use: (Please circle)

cigarettes / tobacco / alcohol /

other substance _____

Are you pregnant or nursing? Y / N

Circle all that apply:

I currently wear: Glasses / Contacts / Sunglasses

I am interested in: Glasses / Contacts / Sunglasses

Laser Vision Correction

I work at a computer: _____ Hours/Day

I have trouble seeing:

Distance / Reading

Computer / Nighttime / Driving

In Bright Lights / Sunlight

Do you have any children at home? Y / N

Are you having any problems with your vision? Y / N

If yes, please describe: _____

What type of work do you do? _____

What sun protection do you currently wear? _____

What hobbies/activities do you enjoy? _____

Do you engage in any activities that could cause eye injury?

Y / N

What do you like (Y) or dislike (N) about your current eye-wear?

[] Weight [] Thickness [] Fit [] Size

[] Shape [] Durability [] Style [] Color

If you are a contact lens wearer, what do you like (Y) or dislike (N) about your current lenses?

[] Vision [] Comfort [] Convenience

[] Dryness