MEDICAL HISTORY AND LIFESTYLE QUESTIONNAIRE

DATE:_____

Patient Name:_____

Describe in your own words why you are seeing us today (Check all that apply):
☐ Check Eye Health ☐ Get Glasses/Contacts ☐ Other: _____
Please list all major injuries, surgeries, or hospitalizations pertaining to eyes or head:

_____

_____

Please **circle** (Y) if Yes, you have the following, (N) No, if you do not & (F) if a Family member has it. Relationship:
If you circled (F), list who has/had it and on what side of the family: maternal / paternal

Medical History		Relationship	Eye Health		Relationship
Unusual Weight Gain/Loss	Y / N / F		Glaucoma (Surgery: Yes / No)	Y / N / F	
Sleep Problems	Y / N / F		Cataracts (Which Eye?)	Y / N / F	
Fatigue/Weakness	Y / N / F		Macular Degeneration	Y / N / F	
Heart Condition	Y / N / F		Eye Injury/Surgery	Y / N / F	
High Blood Pressure	Y / N / F		Retinal Disease	Y / N / F	
High Cholesterol	Y / N / F		Blindness	Y / N / F	
Ear/Nose/Throat Problems	Y / N / F		Eye Turn (Strabismus)	Y / N / F	
Breathing Condition	Y / N / F		Lazy Eye (Amblyopia)	Y / N / F	
Lung Condition	Y / N / F		Diabetic Eye Disease	Y / N / F	
Stomach/Intestinal	Y / N / F		Dry Eye	Y / N / F	
Genitourinary- **genital and urinary**	Y / N / F		Do you or have you used: (please circle) Cigarettes / Tobacco / Alcohol / Other_____		
Muscle / Bone / Arthritis	Y / N / F				
Skin Rashes	Y / N / F		Circle all that apply: I currently wear: Glasses / Contacts / Sunglasses		
Skin Cancer	Y / N / F				
Neurological	Y / N / F		I am interested in: Glasses / Contacts / Sunglasses Getting an Rx for Laser Vision Correction		
Headaches	Y / N / F				
Anxiety / Depression	Y / N / F		I work at a computer _____ hours a day		
Psychiatric Diagnosis	Y / N / F				
Endocrine	Y / N / F		Are you having problems with your vision? Y / N If yes, please describe: (Exp. blur, glare, double vision) _____ _____		
Diabetes: Type 1 or 2	Y / N / F				
Thyroid (Hypo or Hyper)	Y / N / F				
Blood / Lymph Disorders	Y / N / F		What type of work do you do?_____ Hobbies?_____		
Allergies (Seasonal or Food ?)	Y / N / F		What sun protection for your eyes do you currently wear? _____ Do you have sunglasses in your most recent Rx? Y / N		
Cancer (What type?)	Y / N / F				
Other:	Y / N / F				

Please attach or list current medications and dosage (Prescribed or over the counter):

_____

_____

Any allergies to medications?_____