FAMILY FOCUS EYECARE

Medical History Questionnaire

All information contained within this form is strictly confidential.
Please complete this document prior to your first appointment.

Name _____ Date _____

Visual Correction Information

CONTACT LENS HISTORY

Do you wear contacts? ☐ Yes ☐ No

What contact brand do you use? _____

How old are the current contacts you are using? _____

How often do you replace your contacts? _____

What contact solution do you use? _____

Are you happy with your current contacts? ☐ Yes ☐ No

Do you plan to purchase new contacts today? ☐ Yes ☐ No

How many nights per week do you sleep in your contacts?

_____

Check any of the following statements that apply:

- ☐ You experience blurred vision while wearing contacts.
- ☐ You would like to stop using over the counter readers.
- ☐ You are interested in colored contacts.
- ☐ Your back up glasses are more than 3 years old.
- ☐ You have dry eyes or allergies.

GLASSES HISTORY

Do you wear glasses? ☐ Yes ☐ No

If yes, how old is your current/primary pair? _____

Are you happy with your primary glasses? ☐ Yes ☐ No

If no, please describe _____

How old is your current pair of prescription sunglasses?

_____

Check any of the following statements that apply:

- ☐ Your vision is blurred while wearing your glasses.
- ☐ You experience problems with glare.
- ☐ You are allergic to nickel (frames).
- ☐ You are interested in having a back up pair of glasses
- ☐ You are interested in having prescription sunglasses.

How many hours a day do you spend on a computer?

_____

Do you have trouble seeing your computer? ☐ Yes ☐ No

Eye Health Information

HAVE YOU EVER BEEN DIAGNOSED OR EXPERIENCED ANY OF THE FOLLOWING?

Yes	No		Yes	No	
☐	☐	Cataract	☐	☐	Blurred Vision
☐	☐	Corneal Problems	☐	☐	Burning
☐	☐	Macular Degeneration	☐	☐	Distorted Vision/Halos
☐	☐	Glaucoma	☐	☐	Excess tearing/watering
☐	☐	Diabetic Retinopathy	☐	☐	Itching
☐	☐	Dry Eye	☐	☐	Redness
☐	☐	Eye Infection, Inflammation, or Allergy	☐	☐	Sandy or Gritty Feeling
☐	☐	Flashes of Light	☐	☐	Styes or Chalazion
☐	☐	Floaters	☐	☐	Eye Pain/Soreness
☐	☐	Iritis or Uveitis	☐	☐	Mucus Discharge
☐	☐	Retinal Defects or Degenerations	☐	☐	Tired/Lazy Eyes
☐	☐	Chronic Eye/Lid Infection	☐	☐	Double Vision

If you answered yes or have any other eye condition, please explain and list your current ocular medications or drops including artificial tears:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

General Medical History

Do you have any of the following?
(Check all that apply)

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart Disease ☐
- High Cholesterol ☐
- HIV ☐
- Hypertension (High blood pressure) ☐
- Stroke/ CVA ☐
- Migraines/headaches ☐
- Multiple Sclerosis ☐
- Thyroid Disease ☐
- Other: _____

_____

Primary Care Physician Name _____

Primary Care Physician Office _____

Height _____ Weight _____ Date of last medical exam _____

Please list any major surgeries:

_____

_____

_____

_____

Please List any medications you are currently taking and for what conditions:

_____

_____

_____

_____

Please list any drug allergies you have:

_____

_____

_____

_____

Social History

All information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐Yes ☐No

Do you have visual difficulty when driving? ☐Yes ☐No

If yes, please describe _____

_____

Do you use tobacco products? ☐Yes ☐No

If yes, type/amount/how long _____

Do you drink alcohol? ☐Yes ☐No

If yes, type/amount/how long _____

Do you use illegal drugs? ☐Yes ☐No

If yes, type/amount/how long _____

Have you ever been exposed to or infected with:

☐Hepatitis ☐HIV

Are you pregnant or nursing? ☐Yes ☐ No

Family History (Check all that apply)

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

	Yes	No	Relationship to You
Cancer	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Hyperthyroidism	☐	☐	_____
Hypothyroidism	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Arthritis	☐	☐	_____
Blindness	☐	☐	_____
Eye turn/ Lazy Eye	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataracts	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____

Other _____