# MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Last Eye Exam (Date): ……..…… _____

**Where were you seen for your last eye exam?** _____

Do you wear glasses?: ..……..... O YES O NO

How old are your current glasses? ……..….... _____

Do you wear Contact Lenses?: ……..… O YES O NO

What Brand?:……..…… _____

How many hours / day do you wear your contacts?:…….. _____

How often do you change out your contacts? _____

What solution do you use?:…… _____

How many <u>times a week</u> do you wear your contacts <u>overnight</u>?: _____

Reason for today's visit (check all that apply): **O** Glasses **O** Sunglasses **O** Contacts **O** Interested in Laser Vision Correction

**<u>DISEASE / CONDITION</u>** (**<u>Check all that apply</u>**)

| | | **<u>Self</u>** | **<u>Family</u>** | **<u>(Relationship)</u>** |
|---|---|---|---|---|
| Blindness | …… | **O** | O | _____ |
| Cataract | …… | O | O | _____ |
| Crossed Eyes | …… | O | O | _____ |
| Glaucoma | …… | O | O | _____ |
| Macular Degeneration | ……... | O | O | _____ |
| Retinal Detachment / Disease | ……... | O | O | _____ |
| Arthritis | …… | O | O | _____ |
| Cancer | …… | O | O | _____ |
| Diabetes | …… | O | O | _____ |
| Heart Disease | …… | O | O | _____ |
| High Blood Pressure | ……... | O | O | _____ |
| Kidney Disease | …… | O | O | _____ |
| Lupus | …… | O | O | _____ |
| Thyroid Disease | …… | O | O | _____ |
| Asthma | …… | O | O | _____ |
| Skin Problems | …… | O | O | _____ |
| Other: | …… | O | O | _____ |

**<u>SYMPTOMS</u>** (Check all that apply)

O Headaches
O Migraines
O Fainting
O Flashes / Floaters in vision
O Tired eyes
O Vision loss
O Vision blurred
O Distorted / Halos
O Side vision loss
O Double vision
O Dryness
O Allergies / Hayfever
O Mucous discharge
O Redness
O Sandy feeling
O Eyes Itch
O Burning
O Foreign body sensation
O Excess tearing / watering
O Light sensitivity
O Eye pain or soreness
O Infection of eyes or lids

**Are you currently pregnant / breastfeeding?: O YES O NO O N/A**

**MEDICATIONS:** _____

**ALLERGIES (TO MEDICATION):** _____

**SURGERIES (ANY):** _____