MEDICAL HISTORY QUESTIONNAIRE

DATE: ___/___/_____

NAME: ____ **DATE OF BIRTH:** ___/___/_____

WHAT BRINGS YOU IN TO DOVER EYE CARE TODAY? ______________________________________

HOW DO YOUR EYES FEEL? ______________________________________

DO YOU WEAR EYEGLASSES NOW? YES / NO **DO YOU WEAR CONTACT LENSES NOW?** YES / NO

ARE YOU INTERESTED IN SPORTS EYEWEAR? YES / NO **ARE YOU INTERESTED IN CONTACT LENSES?** YES / NO

ARE YOU INTERESTED IN SUNGLASSES? YES / NO

<u>PAST EYE HISTORY:</u> HAVE YOU EVER HAD ANY EYE DISEASES, INJURIES OR SURGERIES? YES / NO IF YES, PLEASE EXPLAIN:

____

<u>MEDICAL HISTORY REVIEW:</u> ARE YOU PRESENTLY BEING TREATED FOR PROBLEMS IN THE FOLLOWING AREAS? (IF YES, PLEASE EXPLAIN)

HEAD & NECK YES / NO ______________________________________

EAR, NOSE & THROAT YES / NO ______________________________________

HEART YES / NO ______________________________________

LUNGS YES / NO ______________________________________

BONES, JOINTS & MUSCLES YES / NO ______________________________________

SKIN YES / NO ______________________________________

NERVOUS SYSTEM YES / NO ______________________________________

<u>DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:</u>

DIABETES YES / NO **GLAUCOMA** YES / NO **CHRONIC INFECTIONS** YES / NO

BLEEDING DISORDER YES / NO **CANCER** YES / NO **HIGH BLOOD PRESSURE** YES / NO

INFLAMMATORY DISEASE YES / NO **ASTHMA** YES / NO **HIGH CHOLESTEROL** YES / NO

SEIZURES OR CONVULSIONS YES / NO

DO YOU CONSUME ALCOHOL? YES / NO **DO YOU USE TOBACCO PRODUCTS?** YES / NO IF YES, WHAT KIND? __________

DO YOU USE ILLEGAL SUBSTANCES? YES / NO

LIST ANY MAJOR MEDICAL ILLNESSES YOU HAVE HAD IN THE PAST: ______________________________________

LIST ANY MEDICATIONS YOU TAKE, INCLUDING VITAMINS & SUPPLEMENTS:

____

LIST ANY MEDICATION ALLERGIES YOU MAY HAVE: ______________________________________

LIST ANY SEASONAL, FOOD OR OTHER ALLERGIES YOU MAY HAVE: ______________________________________

FAMILY HISTORY: IS THERE A **FAMILY HISTORY** OF ANY OF THE FOLLOWING CONDITIONS? **IF YES,** PLEASE INDICATE **FAMILY MEMBER (<u>M</u>**OTHER, **<u>F</u>**ATHER, **<u>G</u>**RANDPARENT, **<u>S</u>**IBLING**)**

GLAUCOMA YES / NO _____ **RETINITIS PIGMENTOSA** YES / NO _____ **CATARACTS** YES / NO _____

MACULAR DEGENERATION YES / NO _____ **BLINDNESS** YES / NO _____ **RETINAL DETACHMENT** YES / NO _____

DIABETES YES / NO _____