Eye Solutions, Inc.
Medical History Questionnaire

Name:_____ **Date:**_____

Medication Allergies:_____
List any medications that you are currently taking:_____
_____
_____
_____
List major injuries, surgeries and hospitalizations:_____
_____
_____
_____
Height:_____ Weight:_____ Are you pregnant and/or nursing: ☐ yes ☐no
Do you wear glasses? ☐ yes ☐no If yes, how old are your lenses?_____
Do you wear contact lenses? ☐ yes ☐no If yes, how old are your lenses?_____
Type of contact lenses: ☐ Soft ☐ Rigid ☐ Extended Wear ☐ Daily Wear
Brand:_____Solution:_____ Are they comfortable? ☐Yes ☐No

Family History
Please note any biological family history (parents, grandparents, siblings, children):

	YES	**NO**	**Relationship to You**
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eye	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Thyroid Disease	☐	☐	_____

Social History
Do you drive? ☐ yes ☐ no Do you have visual difficulty when driving? ☐ yes ☐ no If yes, please explain:_____
Do you use tobacco? ☐ yes ☐ no Type/amount/how long?_____
Do you drink alcohol? ☐ yes ☐ no Amount _____Drinks/week - month - year
Do you use recreational drugs: ☐ yes ☐ no Type/amount/how long_____
Hobbies/recreational activities (ie. Hunting, fishing, golfing, sewing, riding motorcycle, etc...)___
_____

Please turn over paper and complete side two

Personal Medical History
Please check all that apply to you. If you do not have any of these conditions, please circle **NO**.

Constitutional: YES or NO
_____Weight Loss
_____Weight Gain
_____Developmental Disability

Ear/Nose/Mouth: YES or NO
_____Allergies/Hay Fever
_____Dry Throat/Mouth
_____Upper Respiratory Infection

Skin: YES or NO
_____Eczema
_____Rosaceae
_____Psoriasis

Respiratory: YES or NO
_____Asthma
_____Emphysema
_____Sleep Apnea
_____COPD

Cardiovascular: YES or NO
_____High Blood Pressure
_____Stroke
_____Heart Disease
_____Congestive Heart Failure

Genitourinary: YES or NO
_____Cystitis
_____Gonorrhea
_____Syphilis

Gastrointestinal: YES or NO
_____Crohn's
_____Colitis
_____Other

Musculoskeletal: YES or NO
_____Ankylosing Spondylitis
_____Fibromyalgia
_____Arthritis
_____Muscular Dystrophy

Hematologic: YES or NO
_____Anemia
_____High Cholesterol
_____Leukemia
_____Other

Immunologic: YES or NO
_____Rheumatoid Arthritis
_____Lupus
_____HIV or AIDS
_____Hepatitis

Psychiatric: YES or NO
_____Depression
_____Bipolar Disorder
_____Anxiety Disorder
_____Attention Deficit Disorder

Endocrine: YES or NO
_____Thyroid
_____Type 1 Diabetes
_____Type 2 Diabetes

EYES: ***Please check all that apply to you.***

_____Eye Turn
_____Lazy eye
_____Drooping eyelids
_____Glaucoma
_____Retinal detachment
_____Cataracts
_____Macular Degeneration
_____Eye Injury _____
_____Eye Surgery_____

_____Dry Eyes
_____Double Vision
_____Itching Eyes
_____Floaters
_____Flashes of light
_____Glare/Light Sensitivity
_____Styes
_____Red appearance to eyes
_____Tired Eyes