

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Skin: YES or NO

- Eczema
- Rosacea
- Psoriasis

Cardiovascular: YES or NO

- High Blood Pressure
- Stroke
- Heart Disease
- Congestive Heart Failure

Gastrointestinal: YES or NO

- Crohn's
- Colitis
- Other

Hematologic: YES or NO

- Anemia
- High Cholesterol
- Leukemia
- Other

Psychiatric: YES or NO

- Depression
- Bipolar Disorder
- Anxiety Disorder
- Attention Deficit Disorder

Ear/Nose/Mouth: YES or NO

- Allergies/Hay Fever
- Dry Throat/Mouth
- Upper Respiratory Infection

Respiratory: YES or NO

- Asthma
- Emphysema
- Sleep Apnea
- COPD

Genitourinary: YES or NO

- Cystitis
- Gonorrhea
- Syphilis

Musculoskeletal: YES or NO

- Ankylosing Spondylitis
- Fibromyalgia
- Arthritis
- Muscular Dystrophy

Immunologic: YES or NO

- Rheumatoid Arthritis
- Lupus
- HIV or AIDS
- Hepatitis

Endocrine: YES or NO

- Thyroid
- Type 1 Diabetes
- Type 2 Diabetes

EYES: Please check all that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Lazy eye | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Itching Eyes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glare/Light Sensitivity |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Styes |
| <input type="checkbox"/> Eye Injury _____ | <input type="checkbox"/> Red appearance to eyes |
| <input type="checkbox"/> Eye Surgery _____ | <input type="checkbox"/> Tired Eyes |