Medical History Questionnaire

Do you wear contact lenses?	Name:	M. P. J. A.	HAMIN STEEL		W Billey begin	Sex: M F Date	e:
City: State: Zip: Work / Cell: Birth Date:	Address:					Home Phone	e:
Birth Date:							and american services in
Medical Doctor: Employer: New Patients: How did you hear about us?						Last Eye Ex	am:
Medical History Do you have any allergies to medications?							
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Do you have any allergies to medications?	Medical History						
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): List all major injuries, surgeries and/or hospitalizations you have had: List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: Are you pregnant and/or nursing?		ions?	no 🗖 ye	s If yes	, explain:		
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Cataract		rnospitan	zations you	nave nac	1:		
Cataract	HAILIBRAYON						
Are you pregnant and/or nursing?	List any of the following that you have	e had: cros	ssed eyes, la	azy eye, o	drooping eyelic	l, prominent eyes, glauco	oma, retinal disease,
Do you wear glasses?	cataracts, eye infections or eye injury	Ti barin	*				now a direct
Do you wear contact lenses?	Are you pregnant and/or nursing?	ono,	☐ yes				
Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no no least lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no no least lenses: Rigid Soft Relationship to you solutions: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE/CONDITION NO YES ? RELATIONSHIP TO YOU	Do you wear glasses?	□ no	□ yes	If yes,	how old is you	ur present pair of lenses	?
Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE/CONDITION	Do you wear contact lenses?	no no	☐ yes	If yes,	how old is you	ar present pair of lenses	?
Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE/CONDITION NO YES ? RELATIONSHIP TO YOU Blindness	Type of contact lenses:	□ Soft	☐ Extend	ed Wear	☐ Other	Are they comfortal	ole? 🗆 yes 🗖 no
Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE/CONDITION NO YES ? RELATIONSHIP TO YOU Blindness	Family History						
DISEASE/CONDITION NO YES ? RELATIONSHIP TO YOU Blindness		ts grandn	arents sibl	ings chil	dran: living or	deceased) for the follow	wing conditions:
Blindness							
Cataract						REENTIONSIII 10	100
Crossed Eyes							
Glaucoma		- 10				THE RESERVE OF THE PERSON NAMED IN COLUMN 1	
Macular Degeneration	Secretarian Management (C) (No. 10 Sec. 10 Se						
Retinal Detachment/Disease							
Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease							The state of the s
Diabetes	Arthritis					de medicali de la rac	
Heart Disease	Cancer						
High Blood Pressure	Diabetes						
Kidney Disease	Heart Disease						
Kidney Disease	High Blood Pressure						
Thyroid Disease	Kidney Disease						
	Thyroid Disease Other Other				-		

Social History This	informatio	n is kept str	ictly confider	ntial. However, you may discuss this portion directly with	ı the do	ctor, if you p	refer.
☐ Yes,	, I would	prefer to	discuss r	ny Social History information directly with n	ny doc	ctor.	
Do you drive? □ no □ yes If ye	s, do yo	ı have vi	sual diffic	culty when driving? \square no \square yes If y	es, pl	ease descr	ribe:
Do you use tobacco products? and	у ц	es If yes	, type/am	nount/how long:			
Do you drink alcohol? ☐ no ☐ ye	es If yes	s, type/ar	mount/ho	ow long:			
Do you use illegal drugs? 🗖 no 📮	ves If	ves type	e/amount	/how long			
Have you ever been exposed to or infe							
Review of Systems		Do yo	u currentl	y, or have you ever had any problems in th	e follo	owing area	as:
	NO	YES	?	yaotai	NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT	.10	120	•
Fever, Weight Loss / Gain				Allergies /Hay Fever			
INTEGUMMENTARY (Skin)				Sinus Congestion			
NEUROLOGICAL				Runny Nose / Post-Nasal Drip			
Headaches				Chronic Cough			
Migraines				Dry Throat / Mouth			
Seizures				RESPIRATORY	_		
EYES Loss of Vision				Asthma			
Blurred Vision		0		Emphysema Chronic Bronchitis			
Distorted Vision / Halos	Ö	ū	0	VASCULAR / CARDIOVASCULAR		_	_
Loss of Side Vision		_	v 🗆	Diabetes			
Double Vision			ā	High Blood Pressure		_	ō
Dryness				Heart Pain			ū
Mucous Discharge				Vascular Disease			
Redness				GASTROINTESTINAL			
Sandy or Gritty Feeling				Constipation			
Itching				Diarrhea			
Burning				GENITOURINARY		Salasas	
Excess Tearing / Watering				Genital / Kidney / Bladder			
Foreign Body Sensation				SKELETOMUSCULAR			_
Glare / Light Sensitivity				Rheumatoid Arthritis			
Eye Pain or Soreness Chronic Infection of Eye or I				Muscle Pain Joint Pain			
Sties or Chalazion		ū	ä	LYMPHATIC / HEMATOLOGIC	_		
Flashes / Floaters in Vision	0		ā	Anemia			
Tired Eyes		ā		Bleeding Problems			ū
ENDOCRINE				ALLERGIC / IMMUNOLOGIC			
Thyroid / Other Glands				PSYCHIATRIC			
If you answered YES to any of the a	bove or	have a	condition	not listed, please explain & list medica	tions	:	
				0.7 0.70			

Date

Doctor's Signature

Patient's Signature