Medical History Questionnaire

Vision History

What difficulties are you having with your vision?____________________

Do you wear glasses? **YES** **NO** If yes, how old are your glasses?____________________

How old are your prescription sunglasses?____________________

How many hours do you spend on devices (phone/computer/tablet)?____________________

List any eye conditions, eye injuries or eye surgeries:____________________

Personal Medical History

List all medications (prescriptions, over the counter, vitamins, supplements)

List all allergies____________________

Females, are you pregnant or nursing: NO YES

Please note any general medical history for the following conditions

Condition			If yes, please explain
Respiratory problems (shortness of breath, cough)	NO	YES	
Chronic fatigue, fever, unexpected weight gain/loss	NO	YES	
Ear, nose, throat problems	NO	YES	
Skin conditions (rashes, dryness)	NO	YES	
Musculoskeletal problems (arthritis, muscle pain)	NO	YES	
Heart problems (disease, blood pressure, irregular beat)	NO	YES	
Cancer	NO	YES	
Diabetes	NO	YES	
High Cholesterol	NO	YES	
Kidney Disease	NO	YES	
Liver Disease	NO	YES	
Thyroid Disease	NO	YES	
Neurological Problems (numbness, paralysis, headaches)	NO	YES	
Psychiatric problems (depression, anxiety)	NO	YES	
Other			

Family History

List any medical or eye diseases in the family (heart disease, diabetes, cancer, glaucoma, macular degeneration)