Medical History Questionnaire

EYE CARE NORTHEAS

DATE: _____

PATIENT INFORMATION			
NAME:		BIRTH DATE:	
PHARMACY NAME & ADDRESS			
NAME/ADDRESS OF MEDICAL PHYSICIAN			
EMPLOYER'S NAME/ADDRESS:		EMPLOYER'S PHONE:	

➘ **Please answer all of the following questions. If 'Yes', please further explain.**

Eyes: Date of Last Eye Exam _____ Name of Eye Doctor_____

Do you need a new prescription for eyeglasses or contact lenses today? ☐ NO ☐ YES initial_____

***Note: This is a separate part of the eye exam, called a **REFRACTION**, and may not be covered by your health insurance. If 'NO' and a new prescription is needed at a later date, a new appointment will be necessary.*

Medical History Questionnaire

List Medications you take:

_____

_____

List Major Illnesses/Surgeries:

_____

_____

List any Allergies to medicine or environment:

_____

_____

Have you ever had any Lasik and/or Refractive surgical procedure? ☐ No ☐ Yes If yes, when? _____

Is there any other medical condition you would like us to know about?

_____

_____

If patient is under age 18: Was pregnancy and delivery normal? ☐ No ☐ Yes _____

Any developmental problems? ☐ No ☐ Yes _____

*** PLEASE TURN OVER AND CONTINUE ON THE OTHER SIDE***

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Medical History

			Relationship
Blindness	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Glaucoma	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Macular degeneration	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Retinal problems	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Diabetes	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Stroke	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
High blood pressure	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Tuberculosis	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____
Heart Disease	Self: ☐ No ☐ Yes	Family: ☐ No ☐ Yes	_____

Other: Please explain - _____

Social History

Occupation _____
Lives with _____
Have you ever smoked? ☐ No ☐ Yes
>How many years? _____
>Did you stop? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes
>If yes, how many glasses a day? _____

I certify that I have reviewed the above information and that it is true and complete to the best of my knowledge.

_____ _____
Patient's Signature **Date**