InFocus Eye Care Medical History Questionnaire

Today's Date:___________________________

Last Name: ___________________________**First Name:** ___________________________**Goes by:** _____________________

Date of Birth: ________________ **Primary Medical Doctor:** _______________________**Optometrist:** ___________________

How did you hear about Infocus? ________________________________Self/Friend/Physician/Optometrist/Family Member/Internet

When was your last eye exam?_____________**Where?**_________________**Preferred Pharmacy**? _______________________

Glasses/Contact Lens History:

Do you wear eye glasses? Yes /No What do you use them for? Driving/ Reading/Computer/Full time

Do you want a new prescription for eyeglasses today? Yes/No

Do you wear contact lenses? Yes/ No What type of lenses? Distance/ Monovision/Multifocal

Brand of contacts:______________________

Are you happy with the comfort and vision with your contact lenses? Yes/No

Your Ocular (EYE) History:

Do you have any of the following? Yes/No

If YES, please circle all that apply.

Cataracts	Eye Pain
Glaucoma	Eye Trauma
Macular Degeneration	Dry Eye
Double Vision	"Lazy Eye"
Flashes/Floaters	Vision Loss
Excessive tearing	Blurred Vision
Itching/Burning	

Other:_______________________________

Ocular (EYE) Surgery:

Have you ever had eye surgery? Yes/No

If YES, please circle and provide date of surgery.

Surgical Vision Correction (LASIK/PRK/RK)_____________Date______

Cataract __________________________ Date_________________

Eyelids ___________________________ Date_________________

Eye Muscles ______________________ Date_________________

Retina___________________________ _Date_________________

Other:____

Eye Medications/Drops: **None**

Please list all eye medications or drops you are currently taking.

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Family Ocular (EYE) History: **None**

Please circle ALL that apply and their relationship to you.

Cataracts	(Grand Parent, Parent, Sibling, Cousin, Aunt, Uncle)
Glaucoma	(Grand Parent, Parent, Sibling, Cousin, Aunt, Uncle)
Macular Degeneration	(Grand Parent, Parent, Sibling, Cousin, Aunt, Uncle)
Retinal Detachment	(Grand Parent, Parent, Sibling, Cousin, Aunt, Uncle)

Other:____

Please continue to the other side for more medical history.

Thank you!

Medical History Questionnaire Continued…

Current Medications: **None**

*Please list **ALL** medications (including over-the-counter) you are currently taking or provide a list for our records.*

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Allergies to Medications: **None**

Please list medication allergies and your reaction to them.

____Reaction:______________________________

____Reaction:______________________________

____Reaction:______________________________

Previous Surgery: **None**

Please list any previous surgeries and year they were performed.

____Date:______________________________

____Date:______________________________

____Date:______________________________

____Date:______________________________

Medical History: **None**

Please circle all that apply to you personally.

Diabetes	High Blood Pressure	High Cholesterol	Thyroid Disease	Osteoarthritis
Rheumatoid Arthritis	Heart Disease	Artery Disease/Stroke	Kidney Disease	Reaction to Anesthesia
Asthma or COPD	Lung Problems	Sleep Apnea	Multiple Sclerosis	Depression or Anxiety
Cancer/Type:_____________________		History of PREDNISONE, PLAQUENIL or FLOMAX		

Review of Systems: **None**

*Please circle any **NEW** health problems in the following areas.*

Ears/Hearing	Nose/Sinus	Mouth/Throat	Cardiovascular	Skin/Mouth
Gastrointestinal	Neurological	Musculoskeletal	Immunological	Urinary/Kidney
Psychiatric	Respiratory			

Social History:

Current/Past Occupation:______________________________________ Do you drive? Yes / No

Alcohol use?	Yes/ No	How many drinks per week?__________		
Tobacco use?	Yes/ No	How often?	Every day/Quit	Year you quit?___________
Recreational Drugs?	Yes/No	How often?	Every day/Quit	Year you quit?___________

Signature____**Date**___________

I authorize InFocus Eye Care to access my medication history online **YES** **NO**