Medical History Questionnaire

Today's Date:___________________________

Last Name:____________________**First Name:**________________________ **Goes by:**____________________

Date of Birth:___________________ **Gender: Male / Female** **Gender Identity:** ______________________

PHONE # ____

Primary Medical Doctor (first/last name):____

Optometrist:____

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

When was your last EYE exam?_____________**Where?**_____________________________________

Preferred Pharmacy? (name/location) ____

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 / Possibly ***additional fee may apply***

Do you wear **contact lenses**? Yes / No What type of lenses? Distance/ Mono vision/Multifocal

Do you wear glasses when not wearing your contact lens? Yes/No

Your Ocular (EYE) History:

Do you have any of the following? Yes / No

If YES, please circle all that apply.

Cataracts	Glaucoma
Eye Trauma	Blindness
Macular Degeneration	Dry Eye
Double Vision	"Lazy Eye"
Flashes	Floaters
Excessive tearing	

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.* ***Name & Strength***
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____
____

Allergies to Medications: **None** **Are you allergic to LATEX? Yes / No**
Please list medication allergies and your reaction to them.
______________________________ Reaction: ______________________
______________________________ Reaction: ______________________
______________________________ Reaction: ______________________

Previous Surgeries: **None**
Please list any previous surgeries and year they were performed. (non-eye related)
______________________________ Date: ______________________
______________________________ Date: ______________________
______________________________ Date: ______________________
______________________________ Date: ______________________

Medical History: **None** **Stated Height ____________** **Stated Weight ____________**
Please circle all that apply to you personally.

Diabetes ***(insulin or non-insulin)***	High Blood Pressure	Heart Disease
Artery Disease or Stroke	High Cholesterol	Asthma or COPD
Depression or Anxiety	Kidney Disease/Stones	Lung Problems
Arthritis	Thyroid Disease	Reaction to Anesthesia
Rheumatoid Arthritis	Skin Cancer	Sleep Apnea
	Other Cancer ______________________	

Review of Systems: **None**
Please circle any health problems in the following areas.

Ears/Hearing	Nose/Sinus	Mouth/Throat	Cardiovascular	Skin/Mouth
Gastrointestinal	Neurological	Musculoskeletal	Allergic /Immunological	Urinary/Kidney
Psychiatric	Respiratory	Thyroid	Easy bruising / bleeding	

Social History:

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

Alcohol use? Yes / No How many drinks per week? __________
Do you smoke or chew tobacco? Never Everyday Former - Year you quit? __________
Recreational Drugs? Yes / No

Signature ______________________________ **Date** ______________________

I AUTHORIZE INFOCUS EYE CARE TO ACCESS MY MEDICATION HISTORY ONLINE. YES NO

Revised 11-3-2022