

Medical History Questionnaire

Today's Date: _____

Last Name: _____ First Name: _____ Goes by: _____

Date of Birth: _____ 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.

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.**

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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**

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 (<i>insulin or non-insulin</i>)	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