Family Vision Care
Maria A. Stanley, O.D. Inc.

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: Date of Birth:

PERSONAL EYE HISTORY

Date of last eye exam: Name of Doctor or clinic:

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?

Are you experiencing any of the following? (Check any that apply.)

☐ Blurred Vision	☐ Dryness/Grittiness	☐ Floaters	☐ Sun Sensitivity
☐ Burning	☐ Excessive Tearing	☐ Glare at Night	
☐ Double Vision	☐ Flashes of Light	☐ Redness	

Have you ever been diagnosed or treated for the following? (Check any that apply.)

☐ Cataracts	☐ Eye Infection	☐ Lazy Eye	☐ Other Eye Disorder (List)
☐ Corneal Abrasion	☐ Eye Injury	☐ Macular Degeneration	
☐ Crossed Eye	☐ Iritis/Uveitis	☐ Retinal Disease	

PATIENT MEDICAL HISTORY

Have you ever been diagnosed or treated for the following? (Check any that apply.)

☐ Allergy/Immunologic	☐ Endocrine (Diabetes)	☐ Hematologic (Blood)/Lymphatic	☐ Respiratory (Lungs)
☐ Cardiovascular (Heart)	☐ Gastrointestinal (Stomach, etc.)	☐ Neurologic (Headaches, Migraines)	☐ Skin Musculoskeletal
☐ Ears, Nose, Throat	☐ Genitourinary (Prostate, Bladder, etc.)	☐ Psychiatric	☐ Other (List)

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain:

List any medications you take: (including oral contraceptives, over the counter medications, eye drops, and vitamins)

List all major injuries, surgeries and/or hospitalizations you have had:

Women only: Are you currently pregnant and/or nursing? ☐ Yes ☐ No

Do you use? (Check any that apply.) ☐ Alcohol ☐ Cigarettes ☐ Recreational Drugs ☐ Tobacco

Have you ever been exposed/infected with? (Check any that apply.) ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

FAMILY HISTORY

Do any of your immediate family members have? (Check any that apply.)

Relationship to you:	Relationship to you:	Relationship to you:
☐ Blindness	☐ Glaucoma	☐ Macular Degeneration
☐ Cataract	☐ Heart Disease	☐ Retinal Detachment/Disease
☐ Corneal Problem	☐ High Blood Pressure	☐ Other (List)
☐ Diabetes	☐ Lazy Eye	

Doctor's initials: Date:

Thank you for taking your time to inform us so we can better serve your needs.