Byers Eye Care | Medical History Questionnaire

Medical History

Are you allergic to any medications? **No** ◯ **Yes** ◯ *If your answer is yes, list them above.*

Write or provide a list of the medications that you are taking; include contraceptives, vitamins, and OTC medicines.

Write the surgeries and hospitalizations that you have had.

Mark the following illnesses where appropriate:

You	Family		You	Family		You	Family	
◯	◯	Asthma	◯	◯	Cancer	◯	◯	Thyroid Problems
◯	◯	Diabetes	◯	◯	Migraines	◯	◯	Lupus
◯	◯	Hypertension	◯	◯	Arthritis	◯	◯	Anemia
◯	◯	Epilepsy	◯	◯	Vascular Problems	◯	◯	Kidney Problems

Are you pregnant? **No** ◯ **Yes** ◯ Breast-feeding? **No** ◯ **Yes** ◯
Do you smoke? **No** ◯ **Yes** ◯ Drink alcohol? **Never** ◯ **Socially** ◯ **Frequently** ◯

Have you been infected with or exposed to any of these diseases?
Gonorrhea ◯ Syphilis ◯ Aids ◯ Hepatitis ◯

Ocular History

Mark the following conditions where appropriate:

You	Family		You	Family		You	Family	
◯	◯	Crossed Eyes	◯	◯	Cataracts	◯	◯	Surgery
◯	◯	Glaucoma	◯	◯	Infections or Injuries	◯	◯	Other
◯	◯	Retinal Problem	◯	◯	Macular Degeneration			

When was you last eye exam? _____
Have you used glasses before? **No** ◯ **Yes** ◯ Do you use glasses now? **No** ◯ **Yes** ◯
Do you use contact lenses? **No** ◯ **Yes** ◯ Type of contacts? **Soft** ◯ **Hard** ◯

Mark the following that you have or have had in the eyes:

◯ Loss of Vision	◯ Discharge	◯ Constant Watering
◯ Blurry Vision	◯ Sandy Feeling	◯ Pain
◯ Double Vision	◯ Itching	◯ Flashes of Light
◯ Dryness	◯ Burning	◯ Floaters
◯ Redness	◯ Tired Eyes	◯ _____

Signature (Parent or Guardian if under 18)_____**Date**_____