BYERS EYE CARE | MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

Are you allergic to any medications? No O | Yes O *If Yes, please list them*:_____

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

_____

List any major surgeries and hospitalizations that you have had.

_____

Mark the following where appropriate if you and/or a hereditary family member have been diagnosed.

Self	Family		Self	Family		Self	Family	
O	O	Diabetes	O	O	Arthritis	O	O	Migraines
O	O	High Blood Pressure	O	O	Neurological Conditions	O	O	Anemia
O	O	High Cholesterol	O	O	Asthma / COPD	O	O	Liver Condition
O	O	Thyroid Condition	O	O	Cancer	O	O	Kidney Condition

Do you smoke? No O | Yes O

Do you drink? No O | Yes O

Are you Pregnant or nursing? No O | Yes O

Have you ever been infected with or exposed to any of the following:

Gonorrhea: O Syphilis: O Aids: O Hepatitis: O

OCULAR HISTORY

When was your last eye exam?_____

Have you used glasses before? No O | Yes O

Do you use glasses now? No O | Yes O

Do you use contact lenses? No O | Yes O

Type of contact lenses: Soft O | Hard O

Mark the following where appropriate if you and/or a hereditary family member have experienced in the eyes:

Self	Family		Self	Family		Self	Family	
O	O	Crossed Eyes	O	O	Cataracts	O	O	Surgery
O	O	Glaucoma	O	O	Infection / Injury	O	O	Other
O	O	Retinal Problem	O	O	Macular Degeneration			

Mark the following conditions you currently have or have experienced in the eyes:

O Blurry Vision	O Dryness	O Discharge	O Flashes of Light
O Loss of Vision	O Redness	O Sandy Feeling	O Floaters
O Double Vision	O Itching	O Watering	O Other
O Tired Eyes	O Burning	O Pain	

SIGNATURE:_____ **DATE:**_____