

OFFIC	CE USE ONLY
PN:_	
DOS:	

MEDICAL HISTORY QUESTIONNAIRE

Name:						Date of Birth:								
'isio	n C	orrection - De	o yo	u we	ear gl	asses? □ No □] Ye	s D	o you wear contac	ct ler	nses	s? □ I	No □ Yes	
Reas	on(s	s) for Visit – I	n yo	ur o	wn w	ords, please des	cribe	e the	e reason for your v	visit	toda	ay:		
'isua	al Fu	unction Ques	tion	s –	Pleas	e check if <u>you</u> a	re ex	per	iencing difficulty w	ith a	any	of the	following:	
No		Yes						No						
			Reading Small Print						Watch					
			ading Traffic or Street Signs							ng at Night				
			ig in Bright Light							Seeing Steps, Curbs or Stairs				
		Glare							Floate		r Fla	shes		
		Dry, R	ed, S	Sand	ly or l	tchy Feeling			Other:					
									enous contrast dye					
nviro	onm	ental (includin	g se	aso	nal, fo	ood and latex) al	lergi	es c	or indicate \(\Brightarrow\) NO	KNC	I WC	N ALL	ERGIES.	
Allerg	av		Re	Reaction				Allergy			Reaction			
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Past Ocular and Surgical History - Please check if you have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type): No Yes No Yes Cataract: Cornea: LASIK: Glaucoma: Oculoplastic: Retina: Other: Other: Personal and Family Health History – Please check if you or a family member have / have had any of the following or indicate □ NO RELEVANT PERSONAL HISTORY □ NO RELEVANT FAMILY HISTORY. Self Mother Father Sister Brother **Allergies** Anxiety Auto-Immune Disorder (note type) Blindness Cancer (note type) **Cataracts Corneal Disease** Diabetes (note type) Depression Glaucoma **Heart Disease High Blood Pressure High Cholesterol** Lazy Eye **Macular Degeneration** Migraines **Retinal Disease** Seizure Disorder Stroke **Thyroid Disorder** Other: Other: **Females**: Are you currently pregnant? \square No \square Yes Are you currently breastfeeding? \square No \square Yes **Social History** Have you ever used tobacco? ☐ No ☐ Yes - If yes: ☐ Former ☐ Current Every Day ☐ Current Some Day Tobacco Product: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/chew ☐ Smokeless ☐ Other: _____ Do you drink alcohol? ☐ No ☐ Former ☐ Yes - - If yes: ____ drinks per ☐ Day ☐ Week ☐ Month ☐ Year Do you drink or consume caffeine? ☐ No ☐ Yes - - If yes: ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets

Occupation:

Status: ☐ Full Time ☐ Part Time ☐ Retired / Other