NP ☐ yes

EP ☐ yes

ARTESIA I CARE OPTOMETRY

Medical History Questionnaire

Patient Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Birth Date: _____ Social Security #: _____ Preferred Contact: H ___ C ___ W ___

Guardian (If Applicable): _____ Patient's Occupation: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: _____ Last Eye Exam: _____

With whom may we discuss your medical history (spouse, parent, sibling, etc)? _____

How did you hear about us? _____

Medical History

Do you have any allergies (medications, food, latex, etc)? ☐ no ☐ yes If yes, please list: _____

_____

List all medications you take (including oral contraceptives, aspirin, over the counter and home remedies):

_____

_____

List all major injuries, surgeries, hospitalizations: _____

_____

Have you had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, LASIK, cataracts, eye infections, or eye injury: _____

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present prescription? _____

Do you wear contacts? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Type of contacts: ☐ Hard ☐ Soft ☐ Extended Wear ☐Other Are they comfortable? ☐ yes ☐ no

Brand, if known: _____ Do you sleep in your contacts? ☐ yes ☐ no

Family Medical History

Please note any **family history** parents, grandparents, siblings, children; living or deceased for the following:

Disease/Condition	NO	YES	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other_____	☐	☐	☐	_____