

# Medical / Lifestyle Questionnaire

Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Doctor \_\_\_\_\_

Name of General Physician \_\_\_\_\_ Practice Location \_\_\_\_\_

Is this Eye Exam for?  Glasses  Contact Lenses  Both  LASIK Consultation

## Which of the following would be of interest to you?

- |  |  |
|--|--|
| <input type="checkbox"/> Thinner / Lighter Weight Lenses     | <input type="checkbox"/> Transitions® (Automatic Darkening Lenses) |
| <input type="checkbox"/> Lineless Progressive Bifocal Lenses | <input type="checkbox"/> Prescription Sunglasses                   |
| <input type="checkbox"/> Lenses Without Glare                | <input type="checkbox"/> Additional Pair of Glasses at Half Price  |

## Personal Medical Information: Do you have problems with the following? If yes, please check box.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Health      | <input type="checkbox"/> Genitourinary                | <input type="checkbox"/> Psychiatric (mental)   |
| <input type="checkbox"/> Cardiovascular      | <input type="checkbox"/> Musculoskeletal              | <input type="checkbox"/> Endocrine (Glands)     |
| <input type="checkbox"/> Ear / Nose / Throat | <input type="checkbox"/> Skin                         | <input type="checkbox"/> Blood / Lymph          |
| <input type="checkbox"/> Respiratory         | <input type="checkbox"/> Neurological                 | <input type="checkbox"/> Allergic / Immunologic |
| <input type="checkbox"/> Gastrointestinal    | <input type="checkbox"/> Surgeries (what type & when) | _____   |

Are you allergic to any medications or other substances? Yes  No

If yes, please list \_\_\_\_\_  
\_\_\_\_\_

Please check Yes or No

Do you smoke? Yes  No  How much? \_\_\_\_\_

Do you drink alcohol? Yes  No  How much? \_\_\_\_\_

Do you take medications? Yes  No  Please list names & how often \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do YOU or YOUR FAMILY have a history of any of the following? If yes, please check box.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Eye Injuries    | <input type="checkbox"/> Eye Turn (Strabismus) |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Lazy Eye (Amblyopia)  |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Blindness       | <input type="checkbox"/> Diabetic Eye Disease  |

Please explain any boxes checked (self or which family member) \_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following? If yes, please check box.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Wear Glasses        |
| <input type="checkbox"/> Dry Eyes       | <input type="checkbox"/> Eye Injuries  | <input type="checkbox"/> Wear Contact Lenses |

Please explain any current ocular / visual problems \_\_\_\_\_  
\_\_\_\_\_

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_