Frontier Vision Clinic, P.C.
Medical History Questionnaire

Patient Name:____ **Today's Date:**______________

Reason for Today's Visit:____

Date of Last Eye Exam: ____________ Name of Previous Eye Doctor: _______________________________

Date of Last Medical Exam: _________ Family Medical Doctor: _____________________________________

Current Medications:____

____ Allergies: __________________

List All Major Injuries, Surgeries, and/or Hospitalizations you had:

____

List Any Known Eye Problems:____

Are You Interested In: Glasses_______ Contact Lenses_______ Laser Vision Correction________

Do You Participate In: Shooting____ Skiing____ Golf____ Running____ Biking____ Other_____

Do You Use a Computer Often: Y/N If so, how many hours per day:__________

Do You Drive: Y/N Do you have difficulty when driving, especially at night ___________________

Are You Pregnant or Nursing: Y/N Have you recently had a baby (delivery date): ____________

Family Eye History:

Has any family member been diagnosed with the following:

Disease/Condition	Relationship to You
Blindness	______________________________
Glaucoma	______________________________
Macular Degeneration	______________________________
Retinal Detachment	______________________________
Eye Turn/Lazy Eye	______________________________
Diabetes	______________________________
High Blood Pressure	______________________________
Thyroid Problems	______________________________
Heart Problems	______________________________
Cancer	______________________________
Kidney Disease	______________________________
Arthritis	______________________________
Other ____________	______________________________

Social History (can be discussed directly and confidentially with your Doctor during the examination):

Do you use tobacco, drink alcohol, or use recreational drugs (explain)__________________________

Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis _____________