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 or Clinic: ___________________________________

Date of Last Medical Exam: _____________ Family Medical Doctor or Clinic:______________________________________

Current Medications (include dosages and frequency if known) :____

____

Allergies (medications or environmental): ____

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

____

List Any Eye Surgeries or Injuries____

List Any Known Eye Problems:____

Are You Interested In: Glasses__________ Contact Lenses____________ Laser Vision Correction____________

Have you worn Contact Lenses previously: Y / N Are you currently wearing Contact Lenses: Y / N

If yes, please specify brand/type and power: ____ Solution used: _______________

Do You Participate In: Shooting____ Skiing____ Golf____ Running____ Biking____ Other______________________

How Many Hours Per Day Do You Use a Digital Device (computer, cell phone, tablet): ____________________________

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

Are You Pregnant or Nursing: Y / N Have you recently (in the past 6 months) had a baby (delivery date): _______________

Family and Personal Eye & Health History:

Have **you** or **any** family members been diagnosed with the following:

Disease/Condition	**Relationship to You** (please specify mother or father's side)
Glaucoma	____
Macular Degeneration	____
Retinal Detachment	____
Eye Turn/Lazy Eye	____
Diabetes (Date of your diagnosis)	____
High Blood Pressure	____
Thyroid Problems	____
Heart Problems	____
Cancer (please specify type)	____
Kidney Disease	____
Arthritis	____
Other ______________________	____

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

Do you use chewing tobacco, e-cigs, vape, or use recreational drugs (explain)_____________________________________

Do you smoke: Y / N Frequency & amount: ____

Do you drink alcohol: Y / N Frequency & amount:____

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