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_____

Have you worn Contact Lenses before or are you wearing them now: _____

If yes, what brand/type and power: _____

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/Health History:

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

Disease/Condition	**Relationship to You** (please specify maternal or paternal)
Blindness	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Detachment	_____
Eye Turn/Lazy Eye	_____
Diabetes	_____
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 tobacco, drink alcohol, or use recreational drugs (explain)_____

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