Goldthwait Vision Care

Medical History Questionnaire

Patient Name_____ **DOB**_____

Personal Eye History

Last Eye Exam:_____
Have you ***ever*** worn glasses? Yes / No
Do you currently wear glasses? Yes/ No
Are you restricted to glasses for driving? Yes / No

Do you wear contact lenses? Yes / No
Brand:_____Power: (Right)_____,(Left)_____

Have you ever been diagnosed with any of the following?: *None (Circle)*

- ☐ Cataracts
- ☐ Color deficiency
- ☐ Diabetic retinopathy
- ☐ Dry eye
- ☐ Glaucoma
- ☐ Iritis
- ☐ Keratoconus
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Tear
- ☐ Other_____

History of eye surgery? Yes / No *(Circle one)* Right eye /Left eye / Both Year:_____
For what?:_____ Surgeon's name:_____

Personal Health History

Primary Care Physician's Name & Town they practice in:_____

Have you ever been diagnosed with any of the following?: *None (Circle)*

- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer,Year Diagnosed:_____
- ☐ Cerebral Palsy
- ☐ COPD
- ☐ Diabetes,Year Diagnosed:_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Psychiatric
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sjogren's Disease
- ☐ Stroke, Year Diagnosed:____
- ☐ Thyroid

Do you currently smoke tobacco? Yes / No If no, former smoker? Yes / No How long ago?_____
Vape? Yes / No Past history of drug use? Yes / No

Medications Please list all prescription medications you are taking, INCLUDING oral contraceptives, aspirin and hormones (or you can provide us with a medication list that we can photocopy):

None (Circle)

_____ _____ _____ _____
_____ _____ _____ _____

Allergies Please list any drug allergies you have:_____

Family History (Please mark any/all known problems): *None (Circle)*

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Tear
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Thyroid Disorder