Medical History Questionnaire

Brendhan M. Fritts, O.D. P.C.

Name: _____ Today's Date: _____

Last Eye Doctor: _____ Last Eye Exam: _____ / _____
Month Year

Were you referred to our clinic Yes or No If yes, by who?_____

Medical History

Do you have any allergies to medications? Yes or No If Yes, explain:

_____

_____

List any medications you take:

_____

_____

List all major injuries, surgeries:

_____

_____

Check any of the following that you have had: ☐ reading difficulty ☐ crossed eyes ☐ lazy eye ☐ keratoconus
☐ glaucoma ☐ retinal disease ☐ cataracts ☐ eye injury

Are you pregnant and/or nursing? Yes or No
Do you wear glasses? Yes or No
Do you wear contacts? Yes or No How old is present pair? _____
Type of contact lenses: Rigid or Soft What is current brand? _____
Do you sleep in contacts: Yes or No Average duration before removal? _____
Have you had refractive surgery? Yes or No Name of Surgeon and Year: _____

Ocular History – Have you or any of your relatives, living or deceased, had any of these conditions?

Blindness	Yes	No	Unsure	Relation: _____
Cataract	Yes	No	Unsure	_____
Crossed Eyes	Yes	No	Unsure	_____
Glaucoma	Yes	No	Unsure	_____
Macular Degeneration	Yes	No	Unsure	_____
Retinal Detachment/Disease	Yes	No	Unsure	_____

Review of Systems – Do you currently, or have you ever had any problems in following areas:

Cancer	Yes	No	Unsure
Neurological			
Headaches	Yes	No	Unsure
Migraines	Yes	No	Unsure
Seizures	Yes	No	Unsure
Eyes			
Loss of Vision	Yes	No	Unsure
Blurred Vision	Yes	No	Unsure
Blindness	Yes	No	Unsure
Double Vision	Yes	No	Unsure
Dryness	Yes	No	Unsure
Flashes/Floaters	Yes	No	Unsure
Glare/ Light Sensitivity	Yes	No	Unsure
Chronic Infection Eyelids	Yes	No	Unsure

Vascular			
Diabetes	Yes	No	Unsure
Hypertension	Yes	No	Unsure
Brain Injury/Stroke	Yes	No	Unsure
Bone/Joints/Muscles			
Rheumatoid Arthritis	Yes	No	Unsure
Joint Pain	Yes	No	Unsure
Lymphatic/Hematologic			
Anemia	Yes	No	Unsure
Bleeding Problem	Yes	No	Unsure
Endocrine			
Thyroid Problem	Yes	N o	Unsure
Other Health Issues not listed:			
_____			