ONSIGHT EYE CENTER

Medical History Questionnaire

Patient's First Name
-

Patient's Last Name
-

Patient's Preferred Name
-

Patient's Date of Birth
-

What's the reason for you visit?
-

When was your last eye exam?
-

Name of previous Optometrist:
-

Name of current Primary Care Provider(s):
-

Preferred Pharmacy:
-

Do you wear eyeglasses / spectacles?
-

If yes, select the type of eyeglasses you wear

- ☐ Single Vision
- ☐ Bifocal
- ☐ Trifocal
- ☐ Progressive
- ☐ Other

Do you wear contact lenses?
-

If yes, select the type of contact lens you wear

- ☐ Soft
- ☐ Gas Permeable
- ☐ Monovision

How long has your glasses or contacts current prescription been worn?
-

*Please bring current glasses or contact lens boxes to the appointment. Please bring a copy of the most recent prescription, if available.

Have you undergone laser corrective surgery?
-

If yes, approximately what year was this procedure?
-

Was this procedure LASIK, PRK, RK? Please state procedure and which eye(s):
-

Do you suffer from any known eye conditions? (i.e. cataracts, glaucoma, macular degeneration, retinal detachment, lazy eye, etc.)
-

Please list any eye medications with how many times/day, and which eye(s) you use them in:
-

Are you allergic to any of the following?

- ☐ Antibiotics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Narcotics

Allergy Not Listed:
-

If yes to allergies to any medications, what was your reaction?
-

Please list any medications you are currently taking
-

Can we access your medication history online?

- ☐ Yes
- ☐ No

Check all that apply:

☐ Sudden Blurriness	☐ Hypertension	☐ Double Vision	☐ Flashes/Floaters in vision
☐ Dry Eye/Burning sensation	☐ Itchy Eyes	☐ Redness	☐ Sandy or gritty feeling
☐ Watering eyes	☐ Glare/Light sensitivity	☐ Eye pain	☐ Lazy eye/Eye Turn
☐ Headaches (migraines, ocular headaches)	☐ Diabetes: Insulin	☐ Diabetes: Non-insulin	☐ Thyroid Disorder
☐ Heart Condition	☐ Kidney/Liver Condition	☐ Stomach/Digestive	☐ Skin Condition
☐ Psychological/Neurological	☐ Blood Disorder	☐ Ear/Nose/Mouth/Throat	☐ Cancer
☐ High Cholesterol	☐ Asthma	☐ Arthritis	☐ Multiple Sclerosis
☐ Respiratory	☐ Allergy/Immunology	☐ Other	

If yes, please explain:
-

Have you ever been exposed to or infected with the following?

☐ Gonorrhea	☐ Hepatitis	☐ HIV	☐ Syphilis

Please specify if you have any other health conditions not listed above
-

Please list any major surgeries and/or surgeries in the last 5 years:
-

Please check all that apply

☐ Never used Tobacco	☐ Former Tobacco user	☐ Current Every DayTobacco user	☐ Recreational Drug Use

Alcohol

☐ No Alcohol use	☐ Occasional	☐ 1-2 drinks/day	☐ 3-4 drinks/day

Driving

☐ Currently Drive	☐ Do Not Drive

Current/Past Occupation:
-

Does your family history include any of the following?

☐ Glaucoma	☐ Cataracts	☐ Macular Degeneration	☐ Retinal Detachment
☐ Blindness	☐ Diabetes	☐ Thyroid Condition	

Other:
-

If yes to any, please note which condition(s) and if the relationship is MATERNAL or PATERNAL.
-

Patient's Electronic Signature (ESign)

Date :

Relationship to Patient (if minor)
-