

# PATIENT MEDICAL HISTORY QUESTIONNAIRE

Glasses wearer: yes/no  
wearer: yes/no

Contact Lens

Reason for  
visit/consultation: \_\_\_\_\_

## ALLERGIES

Allergen	Describe Reaction

## OCULAR HISTORY

Disease/Problem	Diagnosed When	Treatment ?	By Whom

## SYSTEMIC MEDICAL HISTORY

Disease/Problem	Diagnosed When	Treatment ?

If Diabetic: Recent Blood Sugar \_\_\_\_\_ When \_\_\_\_\_

## FAMILY HISTORY

Family Member	Diagnosis

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**SOCIAL HISTORY**

**Do you smoke: yes/no/previously**      **If yes, how long** \_\_\_\_\_

**Do you drink Alcohol: yes/no**      **If yes, how**  
**much/frequency** \_\_\_\_\_

**Do your drink caffeine: yes/no**      **If yes, how much**  
\_\_\_\_\_

**Do you use any recreational drugs: yes/no/formerly**