

SOLINSKY EYECARE, LLC
Medical History Questionnaire

Name		Date of Birth:	
1. Please describe any concern or problem you have with your eyes:			
2. Date of last eye exam			
3. Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Make & power:	
4. Do you use any eyedrops? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list:			
5. Please list all medications you are currently taking, including birth control pills and non-prescription medications:			
6. Are you allergic to any medications or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list:			
7. What is (was, if retired) your occupation?			
Do you have:	Yes	No	<i>Reserved for notes</i>
Decreased vision			
Blind spots in vision			
Poor side vision			
Poor night vision			
Poor color vision			
Poor depth perception			
Abnormal sensitivity to light			
Halos around lights			
Problems with glare			
Red eye			
Eye which bulges out			
Puffy eyes			
Eye discomfort			
Eye dryness			
Eye itching			
Pressure in or behind eye			
Mattering of eyes			
Tearing of eyes			
Pus around eyes			
Crusting or red eyelids			
Change in blinking			
Double vision			
Have you had:	Yes	No	
Blurred vision spells			
Decreased vision spells			
Fluctuating vision			
Floaters in your vision			
Flashing lights			
Jagged lines in vision			
Eye surgery			
Eye injury			
Serious eye infection			
Spasm of eyelids			
Retraction of eyelids			
Lazy eyelids			
Abnormal pupil			
Cornea disease			
Glaucoma			
Cataract			
Retinal disorder			
Eye tumor			
In or out-turning of eye			
SOCIAL HISTORY			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How many packs per day?			
Do you consume two or more alcoholic drinks per day? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you concerned that your occupation adversely affects your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TURN OVER TO COMPLETE

