

Medical History / VSP Questionnaire

Name _____ DOB _____ Date _____

Medications

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Drug Allergies: _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Y / N	Nervous	Y / N	Endocrine (glands)	Y / N
Ears/Nose/Throat	Y / N	Urinary	Y / N	Blood/Lymph	Y / N
Cardiovascular	Y / N	Muscles/Bones	Y / N	Allergic/Immunologic	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Headaches	Y / N
High Blood Pressure	Y / N	Eyes	Y / N	Mental	Y / N

Please explain _____

Diabetes Yes/No Type _____ Date of diagnosis _____

Other health problems _____

Have you had any operations? Y / N Kind? _____ When? _____

Name of family doctor _____

Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure Y / N Relation _____	Macular degeneration Y / N Relation _____
Diabetes Y / N Relation _____	Retinal detachment Y / N Relation _____
Glaucoma Y / N Relation _____	Cataracts Y / N Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Y / N What kind? _____

Have you had any eye operations? Y / N Type _____ Date _____

Have you had an eye injury? Y / N Kind? _____ Date _____

Do you have glaucoma? Y / N _____ Cataracts? Y / N _____ Dry eyes? Y / N _____

Macular degeneration? Y / N _____ Retinal detachment? Y / N _____ Blurred vision? Y / N _____

Do you wear glasses? Y / N _____ Contact lenses? Y / N Type _____

Additional information _____