CONSENT TO TREAT PATIENT FORM
&
MEDICAL HISTORY QUESTIONNAIRE

Name:____ Date:_____/_____/_____

Address____________________________________Home Phone________________ Other Phone________________

City ___________________________ State __________________ Zip Code _______________________

Birth Date: ____/____/____ Last Medical Exam:____/____/____ Last Eye Exam____/____/____

Email Address: ____

Name of Parent / Guardian (if Patient is a Minor):____

Medical History

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

____

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): ____

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____

List all major injuries, surgeries, and/or hospitalizations you have had: _____________________________________

____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury. Other: ____________________________________

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses?_________________

Do you wear contacts? No Yes If yes, how old is your present pair of lenses?_________________

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no yes

Family History

Please note any family history (parents, grandparents, siblings, and/or children, living or deceased) for the following medical conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness				______________________
Cataract				______________________
Crossed Eyes				______________________
Glaucoma				______________________
Macular Degeneration				______________________
Retinal Detachment/Disease				______________________
Arthritis				______________________
Cancer				______________________
Diabetes				______________________
Heart Disease				______________________
High Blood Pressure				______________________
Kidney Disease				______________________
Lupus				______________________
Thyroid Disease				______________________
Other:_________________				______________________

Social History (if applicable)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe: ____

Do you use tobacco products? No Yes If yes, type/amount/how long:_____________________________

Do you drink alcohol? No Yes If yes, type/amount/how long: ___________________________________

Please turn this form over and complete side two