# MEDICAL HISTORY QUESTIONNARE

## Patient Social History:

Use Of Alcohol ________ Never ________ Rarely ________ Moderate ________ Daily

Use Of Tobacco ________ Never ________ Quit ________ # of Pack(s)/day

Use Of Illicit Drugs ________ Never ________ Type/Frequency ____________________

## Medical History:

Last Medical Exam ____________________ Where/Doctor ____________________

Last Eye Exam ____________________ Where/Doctor ____________________

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

____________________________________________________________

____________________________________________________________

Do you wear glasses? ________ Yes ________ No

Have you worn glasses in the past (when)? ____________________

Do you wear contact lenses? ________ Yes ________ No

Are you Interested In? ________ Glasses ________ Contacts ________ Lasik ________ Other

____________________________________________________________