THE WOODLANDS LOW VISION CLINIC

Please present your medical or vision insurance card(s) & photo id.

Full Name: _____

Medical History Questionnaire

Reason for today's exam? _____

_____

_____

_____

When was your last eye exam? _____

Any changes in your vision since your last eye exam? _____

_____

_____

_____

Any changes in your general health since your last eye exam?

_____

_____

_____

Do you have a current eye doctor? ☐ Yes ☐ No

If yes, please provide details here:

Current eye doctor: _____ ☐OD ☐MD

Please provide office information you recall (Name / Location / Ph #): _____

When are you scheduled for your next exam? _____

List of Medications (oral, injected, or drops) being taken & for what condition:

1.	5.
2.	6.
3.	7.
4.	8.

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medication(s): _____

Do you have any environmental or other allergies? ☐ Yes ☐ No