MEDICAL QUESTIONNAIRE

(All information given is confidential)

NAME: _____ **DATE:** _____

NAME OF PHYSICIAN REFERRING YOU:_____**DATE OF LAST EYE EXAM:**_____**DR.**_____

DO YOU HAVE ANY PROBLEMS SUCH AS: **Height:**_____ **Weight:**_____

Diabetes	YES	NO
High Blood Pressure	YES	NO
CANCER OF:		
Breast	YES	NO
Prostate	YES	NO
Colon	YES	NO
Other Cancer: _____		
ALLERGIES TO:		
Latex	YES	NO
Sulfa	YES	NO
Penicillin	YES	NO
Other Medication: _____		
SINUS DISEASE/HAY FEVER	YES	NO
HEART DISEASES:		
Bypass Surgery	YES	NO
Tiredness with exertion	YES	NO
Angioplasty	YES	NO
Heart Attack	YES	NO
Heart Failure	YES	NO
Angina (Chest Pain)	YES	NO
Heart Murmur	YES	NO
Irregular Rhythm	YES	NO
NEUROLOGIC DISEASES:		
TIA's	YES	NO
Stroke Or Multiple Sclerosis	YES	NO
Seizures	YES	NO
Carotid Artery Disease	YES	NO
Carotid Artery Surgery	YES	NO
Frequent Headaches	YES	NO
CIRCULATION DISEASES:		
Blood Clots	YES	NO
Bleeding Problems	YES	NO
STOMACHE/INTESTINAL DISEASES:		
Inflammatory Bowel	YES	NO
Diarrhea	YES	NO
Nausea/ vomiting	YES	NO
Bloody Stool	YES	NO
Excessive thirst	YES	NO
Abdominal pain	YES	NO
Constipation	YES	NO
BONE DISEASE:	YES	NO
Osteoporosis	YES	NO
CONSTITUTION:		
Fever/chills	YES	NO
Fatigue	YES	NO
Cough	YES	NO
SJOGRENS SYNDROME:	YES	NO

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EYE COMPLAINTS:		
Eye Pain	YES	NO
Blurred Vision	YES	NO
Double Vision	YES	NO
Floaters	YES	NO
Light Flashes	YES	NO
Itchy Eye	YES	NO
EYE DISEASE/HISTORY:		
Eye Injuries	YES	NO
Blindness	YES	NO
Cataract	YES	NO
Glaucoma	YES	NO
Macular Degeneration	YES	NO
Retinal Detachment	YES	NO
Lazy Eye (Amblyopia)	YES	NO
Glasses (reading/far)	YES	NO
Wandering Eye	YES	NO
Color Vis. Deficiency	YES	NO
Contact Lens	YES	NO
EYE SURGERIES:		
Laser (Right/Left)	YES	NO
Cataract (Right/Left)	YES	NO
Glaucoma (R/L)	YES	NO
Lasik/RK (R/L)	YES	NO
Other: _____		
THYROID DISEASE	YES	NO
LUNG DISEASES:		
Breathing Difficulty	YES	NO
Asthma/wheezing	YES	NO
Emphysema	YES	NO
Bronchitis	YES	NO
Tuberculosis	YES	NO
Shortness of Breath	YES	NO
KIDNEY/BLADDER DISEASES:	YES	NO
Frequent urination	YES	NO
Burning with urination	YES	NO
Penile/vaginal discharge	YES	NO
Bedwetting/accidents	YES	NO
MUSCULAR/ARTHRITIS/SKIN:		
Rheumatoid	YES	NO
Osteoarthritis	YES	NO
Joint/muscle pain	YES	NO
Moles/Rosacea	YES	NO
PSYCHIATRIC	YES	NO
ADHD	YES	NO
Anxiety/Stress/anger	YES	NO
Depression/Sleep issues	YES	NO

PLEASE TURN OVER»

LIST CURRENT MEDICATIONS and SUPPLEMENTS: (ex. Metformin, Omega 3, Losartan, Aspirin, Hydrochlorothiazide, artificial tears, Restasis, Xiidra)_____

_____

_____

MAJOR SURGERIES, INJURIES, AND HOSPITALIZATIONS WITH APPROXIMATE DATES: _____

_____

_____

WHO IS YOUR FAMILY DOCTOR? _____**MARITAL STATUS:** MARRIED SINGLE OTHER: _____
HAVE YOU SMOKED CIGARETTES/TOBACCO? YES NO **STARTING(YR):** _____ **QUIT(YR):** _____
WOULD YOU LIKE MORE INFORMATION ON HOW TO STOP SMOKING?____YES OR NO_____
HOW MANY PACKS A DAY AND FOR HOW LONG: _____
DO YOU DRINK ALCOHOL? □ OCCASIONALLY □ FREQUENTLY □ EXCESSIVELY
IF PATIENT IS A CHILD: BIRTH WEIGHT_____PRETERM? _____ IF YES, HOW EARLY? _____
ANY HEALTH PROBLEMS DURING PREGNANCY FOR CHILD OR MOTHER? _____
PLEASE FILL OUT ADDITIONAL PEDIATRIC FORM IF PATIENT IS A CHILD. _____
PLEASE CIRCLE ANY OF THE FOLLOWING DISEASES IF THEY OCCUR IN YOUR FAMILY MEMBERS:
Glaucoma Cataract Wandering Eyes Lazy Eyes Macular Degeneration Diabetes High Blood Pressure Heart Disease

What is your occupation?_____

What hobbies, sports or other recreational activities do you enjoy?

_____

Please check the activities you would prefer to do with less dependence on glasses:

□ Reading books/newspapers □ Applying Makeup □ Watching live sports
□ Reading medicine labels □ Shaving your face □ Playing sports (golf)
□ Looking at your watch □ card or table games □ watching TV
□ Viewing/dialing cell phone □ Using a computer □ Daytime Driving
□ Knitting or needlepoint □ Using a handheld tablet device □ Nighttime Driving
Other Activities not listed above:

_____

Please share anything else you think may be important about your lifestyle or daily activities:

Please check if you have any of the following symptoms: □ Dry eyes □ Blurry Vision □ Redness □ Burning
□ Itching □ Light Sensitivity □ Fluctuating Vision □ Excess Tearing/Watering eyes □ Tired Eye, eye fatigue
□ Stringy mucus in or around the eyes □ Foreign body sensation □ Contact lens discomfort
□ Scratchy feeling of sand or grit in the eyes □ Have had punctal plugs placement

GENERAL MEDICAL OBSERVATION: _____

ORIENTED TO □ TIME □ PLACE □ PERSON

Reviewed by_____ date_____