MEDICAL QUESTIONNAIRE

Primary reason for today's (first) visit: _____

Review of Eye Symptoms: Circle if you have any of the following:
Loss or blurred vision, double vision, loss of side vision, itching, burning, redness, gritty feeling, tearing. Glare/light sensitivity or halos, eye pain or soreness, eyelid discomfort, styes.

Medical History: Circle if you have any of the following:
Ears, nose or throat, cardiovascular (heart, blood vessels), diabetes, high blood pressure, stroke, respiratory (lungs, breathing), gastrointestinal (stomach/intestines), kidneys, bladder or genitals, Migraines, neurological, allergies, asthma, arthritis (bones/joints), psychiatric, anxiety/depression, sleep disorders
Any other medical conditions? _____

Surgical History: List any major surgical procedures (including eye related):
_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

Medications: List medications (prescribed and OTC) you are currently taking:
_____ _____ _____ _____
_____ _____ _____ _____

Allergies: List any medication and general allergies: _____ _____
_____ _____ _____ _____

Family History: Circle if these diseases are in your family
Eye related: Blindness, Cataract, Glaucoma, Macular degeneration, retinal detachment, or list other:
Medical: diabetes, high blood pressure, thyroid condition, arthritis, lupus, or list other:
_____
_____

Social History:
Do you use tobacco? YES / NO If yes, average _____ packs/day
If no, former smoker? YES / NO If yes, year stopped? _____
Do you drink alcohol? YES / NO If yes, on average _____drinks per day / week / month
Recreational drug or narcotic use? YES / NO If yes, which chemical/drug(s)? _____
Have you ever been treated for a sexually transmitted infection? YES / NO If yes, which one(s)_____
Are you currently pregnant or nursing? YES / NO
Do you wear contact lenses? YES / NO Any interest in contacts? YES / NO
Are you interested in LASIK? YES / NO How often do you use electronic devices? _____

I certify the above Confidential Health History is correct to the best of my knowledge. I will not hold my doctor or his/her associates responsible for any error or omissions that I have made in completion of this form. I will inform my doctor of any changes that occur.

Patient Signature_____ Date_____