

## Medical History Questionnaire

The following will assist the doctors at Western Slope Eye Care in evaluating your eyes and alert us to risks to your eye health

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Current Medical Dr. \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Currently wear: Glasses?  Contact Lenses?  Interested in Contact Lenses?

**ALLERGY** to any medications? \_\_\_\_\_

**MEDICATIONS** you are taking: \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:** (Add any that aren't listed)

Eyes	Yes	No	Circulatory/Heart	Yes	No
Loss of vision	___	___	Anemia	___	___
Blurred vision	___	___	High blood pressure	___	___
Double vision	___	___	Heart disease	___	___
Eye injury	___	___	<b>Neurological</b>		
Eye surgery	___	___	Headaches	___	___
Floaters/Flashes	___	___	Stroke	___	___
Itchy eyes (allergy)	___	___	Seizures	___	___
Crossed or lazy eye	___	___	<b>Respiratory</b>		
Eye pain	___	___	Asthma	___	___
Glaucoma	___	___	Chronic bronchitis	___	___
Cataracts	___	___	Emphysema	___	___
Other (explain) _____			<b>Skin</b> (e.g. rosacea, psoriasis)	___	___
<b>Endocrine</b>			<b>Psychiatric</b>	___	___
Thyroid	___	___	<b>Gastrointestinal</b>		
Diabetes	___	___	Diarrhea	___	___
<b>Bones/Joints/Muscles</b>			<b>Ear/Nose/Throat/Mouth</b>		
Rheumatoid arthritis	___	___	Allergies/Hay fever	___	___
Joint pain	___	___	<b>Genitourinary</b>		
Gout	___	___	Kidney/Bladder/Prostate	___	___
<b>Immune system</b>			<b>Infections</b>		
Lupus	___	___	HIV/AIDS	___	___
Sarcoid	___	___	Hepatitis	___	___
Other _____			<b>Cancer</b>	___	___

### SOCIAL HISTORY

Do you use tobacco products? \_\_\_ \_\_\_ Do you use illegal drugs? \_\_\_ \_\_\_

Do you drink alcohol? \_\_\_ \_\_\_ If so, how frequently? \_\_\_\_\_

Have you been exposed to or infected with: (circle) Gonorrhea Syphilis Herpes

### FAMILY HISTORY

Please indicate with a **check mark** any family history (living or deceased) of the following conditions:

Crossed eyes	___	High blood pressure	___
Glaucoma	___	Cancer	___
Macular degeneration	___	Diabetes	___
Other eye condition _____		Heart Disease	___

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Signature of Doctor

Date of Review \_\_\_\_\_ Changes: Y N Dr. \_\_\_\_\_ Date of Review \_\_\_\_\_ Changes: Y N Dr. \_\_\_\_\_

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