

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? _____		Environmental? _____	
MEDICATIONS you are taking: _____			
CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU: (Add any that aren't listed)			
Eyes	Yes	No	
Loss of vision	___	___	
Blurred vision	___	___	
Double vision	___	___	
Eye injury	___	___	
Eye surgery	___	___	
Floaters/Flashes	___	___	
Infection (herpes, shingles)	___	___	
Crossed or lazy eye	___	___	
Eye pain	___	___	
Glaucoma	___	___	
Cataracts	___	___	
Other (explain) _____			
Endocrine			
Diabetes	___	___	
Thyroid	___	___	
Other _____			
Bones/Joints/Muscles			
Rheumatoid arthritis	___	___	
Joint pain	___	___	
Gout	___	___	
Immune system			
MS	___	___	
Lupus	___	___	
Sarcoid	___	___	
Other _____			
			Circulatory/Heart
			Anemia
			High blood pressure
			Heart disease
			Neurological
			Seizures
			Migraine
			Stroke
			Other _____
			Respiratory
			Asthma
			Chronic bronchitis
			Emphysema
			Skin (e.g. rosacea, psoriasis)
			Psychiatric (depression, other)
			GI Tract (IBS, IBD, Crohn's)
			Pregnant
			Breast Feeding
			Ear/Nose/Throat/Mouth
			Cancer: Type _____ Active? _____
			Kidney/Bladder/Prostate
			Infections
			Hepatitis
			HIV/AIDS
			Other _____
			History of Steroid Use?

SOCIAL HISTORY			
Do you use tobacco products? Y / N	In the past? Y / N	Do you use marijuana? Y / N	
Do you drink alcohol? Y / N	How often? _____	Drug addiction? Y / N	
Have you been exposed to or infected with: (circle) Syphilis Herpes Chlamydia			
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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