Center For Sight
Medical Questionnaire

Name _____Date of Birth: _____Date:_____

Date of **last Eye exam** **Review Date:**

List any **medications** you currently take (RX and over the counter):_____
Do you have allergies to any medications? **YES NO** If YES, list the medications: _____
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (Concussion, etc.):_____
List any **surgeries** you have had (cataract, appendectomy):_____

Please check the correct box on all medical conditions below, If **YES**, please provide additional information where needed.

Please do not leave any category blank	YES	NO	Details
EYES (Poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ADDITIONAL MEDICAL CONDITION not listed			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? **____ YES _____ NO _____UNKNOWN**
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **_____YES NO_____**
***Are you interested in Lasik Surgery? ____**YES NO___ Would you like a free Lasik consultation? ___ YES NO____**
Have you ever had a blood transfusion? ____YES NO **____**
Do you drink alcohol _____YES NO **_____** If YES, how much? _____
Do you smoke? _____YES NO**____** If YES, how much? _____ How Many Years? _____

*Physician's Signature*_____ *Date*_____

*Review Date*_____*Physician's Signature*_____

Revised 3/25/14