River Vale Eyecare

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date:_____

Date Of Birth: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

Do you have any allergies to medications? ____No ____Yes
If yes, explain: _____

List all major injuries or surgeries to your eyes: _____

Do you wear glasses? ____No ____Yes
Do you wear contact lenses? ____No ____Yes Brand of contact lenses _____
Type of contact lenses: ____Rigid ____Soft ___Extended Wear ___Other

Are you pregnant or nursing? ____No ____Yes Due Date:_____
Do you drink alcohol: ____No ____Yes If yes, type/amount/how long _____
Do you use tobacco products? ____No ____Yes If yes, type/amount/how long _____
Do you use illegal drugs? ____No ____Yes If yes, type/amount/how long _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings) for the following:

	No	Yes	Relationship to You
Blindness	____	____	_____
Retinal Detachment/Disease	____	____	_____
Cataract	____	____	_____
Crossed Eyes /"Lazy Eye"	____	____	_____
Glaucoma	____	____	_____
Macular Degeneration	____	____	_____
Arthritis	____	____	_____
Cancer	____	____	_____
Diabetes	____	____	_____
Heart Disease	____	____	_____

REVIEW OF SYSTEMS

Do you currently have or have you ever been treated for:

EYES	No	Yes
Glaucoma	___	___
Macular degeneration	___	___
Cataracts	___	___
Retinal Disease/detachment	___	___
Lazy Eye(s)	___	___
Double Vision	___	___
Loss of Side Vision	___	___
Flashes/Floaters	___	___
Blurred Vision	___	___
Burning	___	___
Dryness	___	___
Redness	___	___
Foreign Body Sensation	___	___
Sandy or Gritty Feeling	___	___
Sty or Chalazion	___	___
Eye Pain or Soreness	___	___
Mucous Discharge	___	___
Glare/Light Sensitivity	___	___
Excess Tearing/Watering	___	___
Itching	___	___

VASCULAR/CARDIO	No	Yes
High Blood Pressure	___	___
Heart Disease	___	___
High Cholesterol	___	___

NEUROLOGICAL

Headaches	___	___
Migraines	___	___
Seizures	___	___

ENDOCRINE

Thyroid Disease/Dysfunction	___	___
Diabetes Type 1	___	___
Diabetes Type 2	___	___

LYMPHATIC/HEMATOLOGIC

Bleeding Problems	___	___
Anemia	___	___

BONES/JOINTS/MUSCLES

Rheumatoid Arthritis	___	___
Osteoartritis	___	___
Osteoporosis	___	___

ALLERGIC/IMMUNOLOGIC

Lupus	___	___
HIV	___	___

OTHER- PLEASE EXPLAIN:

_____

RESPIRATORY

Asthma	___	___
Chronic Bronchitis	___	___
Emphysema	___	___

_____

_____