MEDICAL QUESTIONNAIRE

(All information given is confidential)

NAME: ______________________________ **DATE:** ______________________________

NAME OF PHYSICIAN REFERRING YOU: ______________________________

DO YOU HAVE ANY PROBLEMS SUCH AS:

Diabetes YES NO

High Blood Pressure YES NO

CANCER OF:

Breast YES NO

Prostate YES NO

Colon YES NO

Other Cancer: ____________________

ALLERGIES TO:

Latex YES NO

Sulfa YES NO

Penicillin YES NO

Other Medication: ____________________

SINUS DISEASE/HAY FEVER YES NO

HEART DISEASES:

Bypass Surgery YES NO

Angioplasty YES NO

Heart Attack YES NO

Heart Failure YES NO

Angina (Chest Pain) YES NO

Heart Murmur YES NO

Irregular Rhythm YES NO

NEUROLOGIC DISEASES:

TIA's YES NO

Stroke YES NO

Seizures YES NO

Carotid Artery Disease YES NO

Carotid Artery Surgery YES NO

Frequent Headaches YES NO

CIRCULATION DISEASES:

Blood Clots YES NO

Bleeding Problems YES NO

STOMACHE/INTESTINAL DISEASES:

Inflammatory Bowel YES NO

Other: ____________________

BONE DISEASE:

Osteoporosis YES NO

EYE COMPLAINTS:

Eye Pain YES NO

Blurred Vision YES NO

Double Vision YES NO

Floaters YES NO

Light Flashes YES NO

Itchy Eye YES NO

EYE DISEASE/HISTORY:

Eye Injuries YES NO

Blindness YES NO

Cataract YES NO

Glaucoma YES NO

Macular Degeneration YES NO

Retinal Detachment YES NO

Lazy Eye (Amblyopia) YES NO

Wandering Eye YES NO

Color Vis. Deficiency YES NO

Contact Lens YES NO

EYE SURGERIES:

Laser (Right/Left) YES NO

Cataract (Right/Left) YES NO

Glaucoma (R/L) YES NO

Lasik/RK (R/L) YES NO

Other: ____________________

THYROID DISEASE YES NO

LUNG DISEASES:

Breathing Difficulty YES NO

Asthma YES NO

Emphysema YES NO

Bronchitis YES NO

Tuberculosis YES NO

Shortness of Breath YES NO

KIDNEY/BLADDER DISEASES: YES NO

ARTHRITIS:

Rheumatoid YES NO

Osteoarthritis YES NO

LIST CURRENT EYE AND OTHER MEDICATIONS: ______________________________

____

MAJOR SURGERIES, INJURIES, AND HOSPITALIZATIONS WITH APPROXIMATE DATES: ____________________

____

WHO IS YOUR FAMILY DOCTOR? ____________________ **MARITAL STATUS:** MARRIED SINGLE OTHER: __________

HAVE YOU SMOKED CIGARETTES/TOBACCO? YES NO **STARTING(YR):** ____________ **QUIT(YR):** __________

HOW MANY PACKS A DAY AND FOR HOW LONG: ______________________________

IF PATIENT IS A CHILD: BIRTH WEIGHT_________PRETERM? __________ IF YES, HOW EARLY? ____________________

ANY HEALTH PROBLEMS DURING PREGNANCY FOR CHILD OR MOTHER? ______________________________

PLEASE CIRCLE ANY OF THE FOLLOWING DISEASES IF THEY OCCUR IN YOUR FAMILY MEMBERS:

Glaucoma Cataract Wandering Eyes Lazy Eyes Macular Degeneration Diabetes High Blood Pressure Heart Disease