Date: / / **Medical History Questionnaire** **Loveland Eyecare, LLC**

Do you have any problems with the following systems?

Eyes (blurred vision, redness, eye pain)…… Yes or No
Ears, Nose, Mouth, Throat (deafness, coughing)…… Yes or No
Allergic (hives, itching, hay fever)…… Yes or No
Psychiatric (depression, confusion, disorientation)…….. Yes or No
Musculo-Skeletal (arthritis, weakness, numbness)……. Yes or No
Endocrine (heat/cold intolerance, excessive thirst)…… Yes or No
Gastrointestinal (nausea, constipation, diarrhea)……. Yes or No
Cardiovascular (swelling of ankles, poor energy)…… Yes or No
Genito-urinary (bleeding, pain on discharge)…….. Yes or No
Neurological (numbness, tingling, paralysis)…….. Yes or No

Immunological (lupus)…….. Yes or No

Hematological (anemia, poor clotting)…… Yes or No
Constitutional (fevers, weight loss)…… Yes or No
Head (headaches)…….. Yes or No

Family Health/Eye History? (Blood Relative)

Glaucoma…… Yes or No
Macular Degeneration…….. Yes or No
Diabetes…….. Yes or No
Lazy Eye…… Yes or No
Blindness…… Yes or No
Retinal Detachment…….. Yes or No

Lifestyle Questions

Do you currently smoke?..... Yes or No
Did you ever smoke?..... Yes or No
If you did smoke, when did you quit?
_____
Do you use illegal drugs?..... Yes or No

Do you drink alcohol regularly?..... Yes or No
Are you pregnant?..... Yes or No
Are you nursing?..... Yes or No

Exam Questions

Do you wear glasses?..... Yes or No
Do you wear contact lenses?..... Yes or No
Are you interested in a contact lens fitting today?..... Yes or No

PATIENT INFORMATION

Last Name _____ **First Name** _____

Address_____
street city state zip

Date of Birth_____**Age**_____**Phone**_____ **Height** _____ **Weight** _____

PATIENT HISTORY: Do YOU have any of the following health problems:

Diabetes……Yes or No
Heart Disease……Yes or No
Asthma……Yes or No
Thyroid Disease……Yes or No
Seizures……Yes or No
High Cholestrol……Yes or No
Cataracts……Yes or No
AIDS/HIV+……Yes or No
Macualr Degeneration……Yes or No
Unexplained Vision Loss……Yes or No

Arthritis……Yes or No
High Blood Pressure……Yes or No
Cancer (type: _____)……Yes or No
Stroke……Yes or No
Migraine Headaches……Yes or No
Non-Migraine Headaches…… Yes or No
Glaucoma……Yes or No
Lazy Eye/Surgery…… Yes or No
Color Blind…… Yes or No

Dry Eye……Yes or No
Eye Pain……Yes or No
Eye Injury……Yes or No
Red/Irritated Eyes…….Yes or No
Watery Eyes……Yes or No
Sensitivity to Light……..Yes or No
Flashes/Floaters……..Yes or No
Itchy Eyes……Yes or No
Eye Surgery……Yes or No

Have you had exposure to: *Hepatities*…..Yes or No / *Syphilis*……Yes or No / *Gonorrhea*……..Yes or No

Check if you experience: *Eyestrain (Distance)*…..Yes or No / *Eyestrain (Computer)*……Yes or No / *Eyestrain (Near)*……..Yes or No

Please list all your **Medications** including eye drops and vitamins (if none, write NONE)

_____

Please list all your **Allergies** including eye drops and vitamins (if none, write NONE)

_____