Mountain Empire Eye Physicians

MEDICAL QUESTIONNAIRE / EYE HISTORY

TODAY'S DATE: _____

PATIENT INFORMATION					
PATIENT LAST NAME:	FIRST:	MIDDLE:	SUFFIX	DATE OF BIRTH	SSN

EYE / VISION RELATED COMPLAINT

REASON FOR YOUR VISIT TODAY?

DOES YOUR VISION CAUSE PROBLEMS WITH: ❑ DRIVING ❑ NIGHT VISION ❑ READING ❑ SPORTS / ACTIVITIES
❑ DEPTH PERCEPTION ❑ COLOR VISION ❑ WATCHING TV ❑ SEWING

SOCIAL HISTORY

DO YOU USE TOBACCO IN ANY FORM? : ❑ YES ❑ NO IF YES, HOW MUCH? _____
DO YOU DRINK ANY TYPE OF ALCOHOL? : ❑ YES ❑ NO IF YES, HOW MUCH? _____
DO YOU USE ANY ILLEGAL DRUGS? : ❑ YES ❑ NO IF YES, HOW OFTEN? _____
HAVE YOU BEEN EXPOSED TO A
SEXUALLY TRANSMITTED DISEASE? : ❑ YES ❑ NO IF YES, WHAT TYPE? _____

MEDICAL HISTORY

DO YOU PRESENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF "**YES**", GIVE AN EXPLANATION. IF YOU HAVE A FAMILY HISTORY CHECK THE FAMILY BOX ALSO.

SYSTEM	**YES**	**NO**	**FAMILY**	**EXPLANATION**
EYES				
BLINDNESS	❑	❑	❑	
CATARACTS	❑	❑	❑	
CROSSED EYE OR LAZY EYE (AMBLYOPIA)	❑	❑	❑	
DRY EYES	❑	❑	❑	
EYE PAIN, SORENESS OR BURNING	❑	❑	❑	
FLOATERS OR SPOTS	❑	❑	❑	
GLAUCOMA	❑	❑	❑	
LOSS OF VISION, DOUBLE OR BLURRED VISION	❑	❑	❑	
REDNESS OR BLOODSHOT	❑	❑	❑	
RETINAL DISEASE OR DETACHMENT	❑	❑	❑	
EYE SURGERY OF ANY KIND (INCLUDING LASERS)	❑	❑	❑	
ANEMIA	❑	❑	❑	
CARDIOVASCULAR (HEART, BLOOD VESSELS, PRESSURE)	❑	❑	❑	
EAR, NOSE, MOUTH, THROAT (SINUS, EAR INFECTIONS)	❑	❑	❑	
ENDOCRINE (DIABETES, THYROID, OTHER GLANDS)	❑	❑	❑	

~ CONTINUED ON REVERSE SIDE ~

GASTROINTESTINAL (STOMACH, INTESTINES)	❑	❑	❑	
GENITOURINARY (GENITALS, KIDNEY, BLADDER)	❑	❑	❑	
HEMATOLOGIC (BLOOD DISORDERS, TRANSFUSIONS)	❑	❑	❑	
INTEGUMENT (SKIN, BREAST)	❑	❑	❑	
MUSCULOSKELETAL (MUSCLES, JOINTS, ARTHRITIS)	❑	❑	❑	
NEUROLOGICAL (HEADACHES, SEIZURES)	❑	❑	❑	
PSYCHOLOGICAL (NERVOUS DISORDER, DEPRESSION)	❑	❑	❑	
RESPIRATORY (LUNGS, BREATHING, ASTHMA, ALLERGIES)	❑	❑	❑	
RHEUMATOLOGIC	❑	❑	❑	
ALLERGIES OR SINUS PROBLEMS	❑	❑	❑	
AIDS, INFECTIOUS DISEASE OR HEPATITIS	❑	❑	❑	
OTHER MEDICAL ISSUES	❑	❑	❑	

PHARMACY, MEDICAL DOCTOR, & ALLERGIES

PREFERRED PHARMACY NAME:	PRIMARY MEDICAL PHYSICIAN AND PHONE NUMBER
PHARMACY PHONE NUMBER:	

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATIONS? : ❑ YES ❑ NO
PLEASE DESCRIBE:

THE ABOVE MEDICAL AND PHARMACY INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE