THE EYE INSTITUTE OF WYOMING, P.C.
MEDICAL HISTORY QUESTIONNAIRE

NAME_____ **TODAY'S DATE**_____

Date of your last eye exam_____ Previous Eye Doctor_____

Date of your last medical exam_____ Current Medical Doctor_____

LIST ANY MEDICATION:

_____

(INCLUDE ORAL CONTRACEPTIVES, ASPRINS, OTC MEDICATIONS, SUPPLEMENTS, AND HOME REMEDIES)

_____

MEDICATION ALLERGIES:_____

Do you wear glasses? Y N How old are your glasses?_____ Do you wear contact lenses? Y N

Brand of contacts?_____ How often do you replace your contacts?_____

Are your contacts comfortable? Y N Do you sleep in your contacts? Y N Type of cleaning solution?_____

Review of Systems

(Please indicate if you have ever had any problems with any of the following areas of your body)

CARDIOVASCULAR
- Heart Disease/Pain Y N _____
- High Blood Pressure Y N _____
- Stroke Y N _____
- Vascular Disease Y N _____

CONSTITUTIONAL
- Weight Loss/Gain Y N _____
- Chronic Fever Y N _____

EARS, NOSE, MOUTH, THROAT
- Allergies Y N _____
- Sinus Congestion Y N _____
- Runny Nose Y N _____
- Chronic Cough Y N _____
- Dry Throat/Mouth Y N _____
- Throat Infection Y N _____

ENDOCRINE
- Thyroid Y N _____
- Diabetes Y N _____
- Hormone Therapy Y N _____

EYES
- Blurred Vision Y N _____
- Double Vision Y N _____
- Glare/Sensitivity Y N
- Burn/Itch Y N _____
- Flashes/Floaters Y N _____
- Pain/Discomfort Y N _____
- Redness Y N _____
- Dryness Y N _____
- Crossed/Lazy Eye Y N _____

GASTROINTESTINOL
- Diarrhea Y N _____
- Constipation Y N _____

GENITOURINARY
- Genitals Y N _____
- Kidney/Bladder Y N _____

HEMATOLOGIC
- Anemia Y N _____
- Bleeding Disorders Y N _____

INTEGUMENTARY (SKIN)
- Rash/Eczema Y N _____

MUSCLE/JOINT/BONES
- Arthritis Y N _____
- Muscle/Joint Pain Y N _____

NEUROLOGICAL
- Headaches/Migraines Y N _____
- Multiple Sclerosis Y N _____
- Head Trauma Y N _____
- Seizures Y N _____

PHYCIATRIC
- Nervous Disorders Y N _____

RESPIRATORY
- Asthma Y N _____
- Bronchitis Y N _____
- Emphysema Y N _____

PREGNANT Y N _____

OTHER

_____

_____

Family History

(Parents, Grandparents, Siblings, Children) for the following

DISEASE/CONDITION	RELATIONSHIP TO YOU
Blindness	_____
Cataracts	_____
Crossed Eyes/ Lazy Eyes	_____
Glaucoma	_____
Macular Degeneration	_____
Retinal Disease	_____
Retinal Detachment	_____
Arthritis	_____
Cancer	(Type) _____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
Kidney Disease	_____
Lupus	_____
Stroke	_____
Thyroid Disease	_____
Other:	_____

Social History

(This can be discussed confidentially with your doctor during the examination)

ACTIVITY	EXPLAIN
Do you use tobacco products?	_____
Do you use alcohol?	_____
Do you use illegal substances?	_____
Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis?	_____

Do you live alone? Y N Do you drive? Y N Any visual difficulty when driving? Y N

Circle activities that you participate in: Shooting/ Running/ Golf/ Tennis/ Biking/ Sewing/ Computer Work