Eagle Family Vision
Medical History Questionnaire

PATIENT'S NAME_____ **DATE OF BIRTH**_____/_____/_____

Do you wear: Glasses? **YES NO** Contact Lenses? **YES NO** Last eye exam: _____
Do you have, or have you had, any of these conditions? Please circle which condition/s or circle **NONE**

AMD Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Arthritis **NONE**

List all medical conditions / surgeries: _____
_____

Medications (prescription and OTC): YES NO If yes, please list_____
_____
_____

Are you allergic to any medications? YES NO If yes, please list: _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	**YES**	**NO**	**SPECIFY CONDITION**
GENERAL/ CONSTITUTIONAL (unintentional weight loss or gain, fatigue, etc.)			
EARS, NOSE, THROAT (earache, hard of hearing, stuffy/ runny nose, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, irregular heart rate, heart disease, etc.)			
RESPIRATORY (breathing problems, congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (impotence, painful urination, frequent urination, jaundice, etc.)			
MUSCLES, BONES, JOINTS (swelling, cramps, joint pain, stiffness, arthritis, etc.)			
SKIN (acne, warts, growths, rash, eczema, etc.)			
NEUROLOGICAL (numbness, weakness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, anemia, etc.)			
IMMUNOLOGIC (lupus, HIV, rheumatoid arthritis, etc.)			

FAMILY MEDICAL HISTORY (INCLUDES MOTHER, FATHER, SIBLING & GRANDPARENT)

Has a member of your family had any of these conditions? Please indicate who next to condition or circle NONE.

AMD_____Cataract_____Glaucoma_____Diabetes_____Hypertension_____Cancer_____Other: _____

SOCIAL HISTORY
Do you drink alcohol? YES NO
Do you smoke? YES NO If Yes to smoking, how much? _____ per day / week / month (please circle)

PATIENT / GUARDIAN SIGNATURE_____ **DATE**_____/_____/_____

Primary Care Doctor: _____ Phone Number: _____