

**CENTURY EYE CARE MEDICAL HISTORY QUESTIONNAIRE**

<b>FIRST NAME</b>	<b>LAST NAME</b>	<b>DATE:</b>
		<b>REFERRING DR.</b>
Home Number:	Daytime Number: ( <input type="checkbox"/> same as home)	Cell Number:
List all medications(you may use the back of this sheet): <input type="checkbox"/> None		
<b>Allergies to medications:</b> <input type="checkbox"/> None		
List all medical conditions: <input type="checkbox"/> None		
List all previous surgeries: <input type="checkbox"/> None		

**SYMPTOMS**

- |                                                                                 |                                                                                    |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recent vision loss     | <input type="checkbox"/> Yes <input type="checkbox"/> No Floaters                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Flashes of light       | <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of peripheral vision |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Night time glare       | <input type="checkbox"/> Yes <input type="checkbox"/> No Tired eyes                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Double vision          | <input type="checkbox"/> Yes <input type="checkbox"/> No Dryness                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tearing                | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye discharge             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Redness                | <input type="checkbox"/> Yes <input type="checkbox"/> No Sandy/gritty feeling      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Itching                | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye pain/ burning         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Foreign body sensation | <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid swelling           |

Please use this space to explain further: \_\_\_\_\_

**GENERAL MEDICAL REVIEW(explain further in space provided)**

- Yes  No Fever \_\_\_\_\_
- Yes  No Weight loss \_\_\_\_\_
- Yes  No Ears/Nose/Throat (sinus,ear infections,chronic cough,dry mouth...) \_\_\_\_\_
- Yes  No Cardiovascular (heart, vessels etc) \_\_\_\_\_
- Yes  No Respiratory (Asthma,emphysema,etc.) \_\_\_\_\_
- Yes  No Gastrointestinal (Stomach ulcers,intestinal disease, etc.) \_\_\_\_\_
- Yes  No Genital, Kidney, Bladder, Prostate \_\_\_\_\_
- Yes  No Muscle, Bone, Joints \_\_\_\_\_
- Yes  No Skin (acne, warts, skin cancer, etc) \_\_\_\_\_
- Yes  No Neurological (multiple sclerosis, strokes, brain tumors, etc) \_\_\_\_\_
- Yes  No Psychiatric (depression, anxiety, ADHD, etc) \_\_\_\_\_
- Yes  No Endocrine (diabetes, thyroid, etc) \_\_\_\_\_
- Yes  No Blood/Lymphatics \_\_\_\_\_
- Yes  No **Have you ever taken Flomax?**
- Yes  No **Do you take blood thinners(Aspirin, Coumadin, Plavix, Vitamin E)?**

**FAMILY HISTORY(write relation next to illness)**

- |                                               |                                                                     |
|-----------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Blindness _____      | <input type="checkbox"/> Retinal detachment _____                   |
| <input type="checkbox"/> Glaucoma _____       | <input type="checkbox"/> Macular degeneration _____                 |
| <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Heart disease or high blood pressure _____ |
| <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Lupus _____                                |
| <input type="checkbox"/> Stroke _____         | <input type="checkbox"/> Thyroid disease _____                      |
| <input type="checkbox"/> Other _____          |                                                                     |

**P: Parents**  
**S: Siblings**  
**GP: Grandparents**  
**CH: Children**  
**AU: Aunt or Uncle**  
**CO: Cousin**

**SOCIAL INFORMATION**

- Retired  Student Occupation: \_\_\_\_\_
- Marital Status:  Single  Married  Divorced  Widow  Lives alone  With \_\_\_\_\_
- Do you drive?  Yes  No
- Do you wear contacts?  Yes  No
- How often do you drink alcohol?  Never  Occasionally  Once daily  2-3 per day  4+ per day
- Do you smoke?  Never  Occasionally  1/2 pack daily  1 pack daily  > 1 pack daily

**THIS SECTION FOR STAFF ONLY**

Phys. Sig: _____ Date: _____	Phys. Sig: _____ Date: _____
Phys. Sig: _____ Date: _____	Phys. Sig: _____ Date: _____