Battleground eyecare Dr. Jon Scott

Medical History Questionnaire

NAME _____ DATE_____

Personal Medical Information

Do you have any problems with any of the following systems? (please circle all that apply)

Gastrointestinal	Neurological (Multiple Sclerosis)	Psychiatric (depression, anxiety)
Ears/Nose/Throat	Genitourinary	Endocrine (diabetes, thyroid)
Cardiovascular (high blood pressure)	Muscles/bones/joints	Blood/lymph
Respiratory (asthma)	Integumentary (skin)	Are you Pregnant/Nursing?

Provide more explanation/other Illnesses or Injuries:_____

_____

Past Surgeries: _____

Diabetes? Y / N Type_____ Last A1C?_____ Date of diagnosis _____

Allergies? Y / N Allergic to What?_____ What happens? _____

Medication Allergy? Y / N Which Meds?_____

Do you smoke? Y / N Drink alcohol? Y / N Recreational/Illicit drugs? Y / N

Name of Family Doctor: _____ Address: _____

Date of last physical: _____

Current Medications/eyedrops: _____

_____

Personal Eye Information

Last eye doctor seen? _____ Date? _____

Have you had any eye surgeries? Y / N Type:_____ Date: _____

Have you had eye injuries ? Y / N Type: _____ Date: _____

With your glasses/contact lenses, are your eyes bothered by? (please circle all that apply):

Sunlight Night Glare Dryness Itching Burning Excessive Tearing Flashes

Floaters Foreign Body Sensation Double Vision Poor Reading or Distance Vision

Have you been told that you have: Cataracts? Y / N Glaucoma? Y / N Macular Degeneration? Y / N

Any other eye conditions (past or present)? _____

Do you wear glasses? Y / N Type (progressive, readers, trifocals, etc)? _____

Do you wear Contact Lenses? Y / N Brand: _____ How many hours/day? _____ Days/week? _____

Brand of lens cleaner? _____

Family History (please circle all that apply)

Hypertension	Relation _____	Macular Degeneration	Relation_____
Diabetes	Relation _____	Retinal Detachment	Relation _____
Thyroid Problems	Relation _____	Cataracts	Relation _____
Cancer	Relation _____		
Glaucoma	Relation _____	Other Eye Conditions?	_____

Do not write below this space

History Reviewed By: _____

Orientation/Affect_____ Date Reviewed: _____