BOREING VISION CLINIC

MEDICAL QUESTIONNAIRE / EYE HISTORY

Name: _____ Date: _____

What brings you to our office? _____

Do you wear glasses for vision? _____

Do you wear contact lenses? _____ If so, last time they were changed? _____

Do you have Glaucoma? _____ If so, how is it being treated? _____

Have you had cataract surgery? _____

Right eye? _____ Date of Surgery: _____ Surgeon: _____

Left eye? _____ Date of Surgery: _____ Surgeon: _____

Did you have any other surgery or eye diseases? _____

Right eye? _____ Date of Surgery: _____ Surgeon: _____

Left eye? _____ Date of Surgery: _____ Surgeon: _____

Last eye exam: _____

What did your doctor tell you? _____

MEDICAL - SOCIAL HISTORY

Medical Doctor's Name _____ Address _____

Were you born prematurely? _____

Have you ever suffered from the following (please check yes or no):

	Yes	No		Yes	No
Headaches, sinus, tonsillectomy	____	____	History of psychological disorder	____	____
Heart condition	____	____	Thyroid disease	____	____
High blood pressure	____	____	Diabetes, if yes, how long?	____	____
Circulatory problems	____	____	Bleeding disorder, anemia	____	____
Lung disease	____	____	Aids or infectious disease	____	____
Ulcers, liver, gall bladder	____	____	Cancer (type)	____	____
Kidney, bladder, prostate disease	____	____	Do you smoke?	____	____
Stroke or neurological disorder	____	____	Do you drink?	____	____

Other surgery, illness or hospitalization not noted above? _____

List any medication allergies: _____

List all the medications you are currently taking, please include eye drops: _____

FAMILY HISTORY

Is there any family history of? (If so, please list the relative for the condition):

Cataracts _____

Glaucoma _____

Retinal Disease _____

Diabetes _____

Hypertension _____

Anemia _____

Other eye or systemic disease