

MEDICAL QUESTIONNAIRE
(All information given is confidential)

NAME: _____

DATE: _____

NAME OF PHYSICIAN REFERRING YOU: _____

DO YOU HAVE ANY PROBLEMS SUCH AS:

DIABETES YES NO
HIGH BLOOD PRESSURE YES NO

CANCER OF:

BREAST YES NO
PROSTATE YES NO
COLON YES NO
OTHER CANCER _____

ALLERGIES TO:

LATEX YES NO
SULFA YES NO
PENICILLIN YES NO
OTHER MEDICATION _____

SINUS DISEASE/HAY FEVER YES NO

HEART DISEASE:

BYPASS SURGERY YES NO
ANGIOPLASTY YES NO
HEART ATTACK YES NO
HEART FAILURE YES NO
ANGINA (CHEST PAIN) YES NO
HEART MURMUR YES NO
IRREGULAR RHYTHM YES NO

NEUROLOGIC DISEASES:

TIA'S YES NO
STROKE YES NO
SEIZURES YES NO
CAROTID ARTERY DIS YES NO
CAROTID ARTERY SX YES NO
FREQUENT HEADACHES YES NO

CIRCULATION DISEASE:

BLOOD CLOTS YES NO
BLEEDING PROBLEMS YES NO

STOMACH/INTESTINAL DISEASE:

INFLAMMATORY BOWEL YES NO
OTHER _____

BONE DISEASE:

OSTEOPOROSIS YES NO

LIST CURRENT EYE AND OTHER MEDICATIONS: _____

EYE COMPLAINTS:

EYE PAIN YES NO
BLURRED VISION YES NO
DOUBLE VISION YES NO
FLOATERS YES NO
LIGHT FLASHES YES NO
ITCHY EYES YES NO

EYE DISEASE/HISTORY:

EYE INJURIES YES NO
BLINDNESS YES NO
CATARACT YES NO
GLAUCOMA YES NO
MACULAR DEGEN YES NO
RETINAL DETACHMENT YES NO
LAZY EYE (AMBLYOPIA) YES NO
WANDERING EYE YES NO
COLOR VIS. DEFICIEN YES NO
CONTACT LENS WEAR YES NO

EYE SURGERIES:

LASER (RIGHT/LEFT) YES NO
CATARACT(RIGHT/LEFT) YES NO
GLAUCOMA(RIGHT/LEFT) YES NO
LASIK/RK (RIGHT/LEFT) YES NO
OTHER

THYROID DISEASE: YES NO

LUNG DISEASE:

BREATHING DIFFICULTY YES NO
ASTHMA YES NO
EMPHYSEMA YES NO
BRONCHITIS YES NO
TUBERCULOSIS YES NO
SHORTNESS OF BREATH YES NO

KIDNEY/BLADDER DISEASE: YES NO

ARTHRITIS:

RHEUMATOID YES NO
OSTEOARTHRITIS YES NO

MAJOR SURGERIES, INJURIES, AND HOSPITALIZATIONS WITH APPROXIMATE DATES: _____

WHO IS YOUR FAMILY DOCTOR: _____

HAVE YOU SMOKED CIGARETTES/TOBACCO? (YES/NO) STARTING (YR) QUIT(YR)

MARITAL STATUS: MARRIED SINGLE OTHER

OCCUPATION: _____ **RETIRED?** YES NO

IF PATIENT IS A CHILD: BIRTH WEIGHT _____ PRETERM YES NO IF YES, HOW EARLY?

ANY HEALTH PROBLEMS DURING PREGNANCY FOR CHILD OR MOTHER?

PLEASE CIRCLE ANY OF THE FOLLOWING DISEASE IF THEY OCCUR IN YOUR FAMILY MEMBERS:

GLAUCOMA, CATARACT, WANDERING EYE, LAZY EYES, MACULAR DEGENERATION, DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE