Central Washington Eye Clinic
Medical Health Questionnaire

Patient Name: _____ **Date of Birth**: _____

Are you allergic to or sensitive to any medications? No _____ Yes _____
If yes, please list and explain: _____
List any medications you currently take (including eye drops, oral contraceptives, aspirin, over the counter medications and home remedies): _____
_____
_____
List all major injuries, surgeries and hospitalizations: _____
_____
List any of the following you have had: Crossed eyes, lazy eye(s), drooping eye lids, prominent eyes, glaucoma, retinal diseases, cataracts, eye infection(s) or eye injury: _____

Are you pregnant or nursing? No _____ Yes _____
Do you wear glasses? No _____ Yes _____ if yes, how old are your present glasses? _____
Do you wear contact lenses? No _____ Yes _____ if yes, how old are you present contacts? _____
What type of contact lenses? Rigid _____ Soft _____ Extended wear _____ Other _____
Are your contact lenses comfortable? No _____ Yes _____

FAMILY HISTORY
Please note any family history of the following conditions:

Disease/Condition	**Mother**	**Father**	**Sister**	**Brother**	**Grandma**	**Grandpa**
Cataract	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____	_____
Retinal Detachment/Disease	_____	_____	_____	_____	_____	_____
Blindness	_____	_____	_____	_____	_____	_____
Crossed eyes	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY
Do you drive? No _____ Yes _____ if yes, do you have any visual difficulty? No _____ Yes _____
If yes, please explain: _____

Do you currently use:
Tobacco? No _____ Yes _____ If no, have you ever? _____ If yes, amount and how long: _____
Alcohol? No _____ Yes _____ Occasionally _____
Illegal Drugs? No _____ Yes _____ If yes, what type and how long: _____

Please turn page over

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REVIEW OF SYSTEMS

Do you currently have or have you ever had any problems in the following areas:

CONSTITUTIONAL	**No**	**Yes**
Fever	_____	_____
Weight loss/gain	_____	_____
INTEGUMENTARY (Skin)		
Rashes/hives	_____	_____
NEUROLOGICAL		
Headaches	_____	_____
Migraines	_____	_____
Seizures	_____	_____
EYES		
Loss of vision	_____	_____
Blurred vision	_____	_____
Distorted vision	_____	_____
Glare	_____	_____
Loss of peripheral	_____	_____
Double vision	_____	_____
Dryness	_____	_____
Mucous discharge	_____	_____
Redness	_____	_____
Itching	_____	_____
Burning	_____	_____
Tearing/watering	_____	_____
Light sensitivity	_____	_____
Eye pain/soreness	_____	_____
Eye/lid infection	_____	_____
Sties or Chalazions	_____	_____
Flashes of light	_____	_____
Floaters	_____	_____
Tired eyes	_____	_____
ENDOCRINE		
Thyroid	_____	_____
Diabetes	_____	_____
Other glands	_____	_____
EAR, NOSE & THROAT		
Allergies/hay fever	_____	_____
Runny nose	_____	_____
Sinus congestion	_____	_____
Dry mouth/throat	_____	_____
Chronic cough	_____	_____
Post nasal drip	_____	_____
ALLERGIES		
Anaphylaxis	_____	_____

RESPIRATORY	**No**	**Yes**
Asthma	_____	_____
Chronic bronchitis	_____	_____
COPD	_____	_____
VASCULAR/CARDIO		
Heart disease	_____	_____
High blood pressure	_____	_____
High cholesterol	_____	_____
GASTROINTESTINAL		
Diarrhea	_____	_____
Constipation	_____	_____
GENITOURINARY		
Genital problems	_____	_____
Kidney	_____	_____
Bladder	_____	_____
MUSCULOSKELATAL		
Arthritis	_____	_____
Rheumatoid arthritis	_____	_____
Muscle pain	_____	_____
Joint pain	_____	_____
LYMPHATIC/HEMATOLOGIC		
Anemia	_____	_____
Bleeding problems	_____	_____
IMMUNE SYSTEM	_____	_____
Cancer	_____	_____
PSYCHIATRIC		
Depression	_____	_____
Other _____	_____	_____

If your have answered yes to any of these conditions or have a condition not listed please provide details:

_____

_____

_____

_____

_____

_____

_____

Patient signature: _____

Date: _____

Medical history is reviewed and signed off on in the patient's electronic health record.