Dr. Carroll, Dr. Lahiff, Dr. Wells

CHEYENNE VISION CLINIC

MEDICAL HISTORY QUESTIONNAIRE

Name (Last, First, M) _____ **Today's Date** _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

☐ CONTACT LENSES
☐ GLASSES
☐ LASER (LASIK) SURGERY
☐ DRY EYE TREATMENT

Other _____

Do you wear glasses? _____ How old are they? _____

Do you wear contact lenses? _____ How old are they? _____

Brand/ Type of Contact Lenses? _____ Are they comfortable? ___ Type of Solution? _____

Date of Last Eye Exam _____ Previous Eye Doctor _____

Date of Last Medical (Physical) Exam _____ Medical Doctor _____

List all **major injuries**, surgeries (including eye), and/or **hospitalizations** (including general anesthesia) you have experienced:

_____

_____

LIST ANY MEDICATION (S) you take (including oral contraceptives, aspirin, OTC medications and home remedies):

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES _____

Are you pregnant or nursing? _____ Have you recently had a baby? _____ Delivery date? _____

Social History (this can be discussed directly and confidentially with your Doctor during the examination)

Do you use tobacco products☐, drink alcohol☐, or use illegal drugs ☐

Explain: _____

Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis ___ _____

Do you drive? _____ Do you have visual difficulty when driving? ___ Difficulty especially at night? ___

Do you have trouble seeing to read ☐, watching television ☐, walking ☐, other: _____?

Do you feel safe at home? ___ Please explain? _____

Family History (parents, grandparents, siblings, children; living or deceased) for the following:

(check those that apply and leave those that do not apply blank)

Disease/Condition		Relationship to you	Disease/Condition		Relationship to you
Blindness	☐	_____	Cancer	☐	_____
Cataract	☐	_____	Diabetes	☐	_____
Crossed Eye /Lazy Eye	☐	_____	Heart Disease	☐	_____
Glaucoma	☐	_____	High Blood Pressure	☐	_____
Macular Degeneration	☐	_____	Kidney Disease	☐	_____
Retinal Detachment	☐	_____	Lupus	☐	_____
Retinal Disease	☐	_____	Thyroid Disease	☐	_____
Arthritis	☐	_____	Other:		_____

Review of Systems

Have you ever had problems with any of the following areas of your body?:

(check those that apply and leave those that do not apply blank)

ALLERGY/IMMUNOLOGIC ☐
CARDIOVASCULAR ☐
Heart Disease/Pain ☐
High Blood Pressure ☐
Stroke ☐
Vascular Disease ☐
CONSTITUTIONAL
Fever, Weight Loss/Gain ☐
EARS, NOSE, MOUTH,THROAT
Allergies/Hayfever ☐
Sinus Congestion ☐
Runny Nose/Post-Nasal Drip ☐
Chronic Cough ☐
Dry Throat/Mouth ☐
Chronic Throat Infections ☐
ENDOCRINE
Thyroid/Other Glands ☐
Hormone Replacement Therapy ☐
Diabetes ☐
EYES
Seeing at night ☐
Loss of Vision/Side Vision ☐
Blurred Vision ☐
Halos/Distorted Vision ☐
Computer Use (how much?) ☐ _____
Double Vision ☐
Flashes/Spots ☐
Lazy Eye ☐
Dryness ☐
Eye Injury ☐
Redness ☐
Sandy/Gritty Feeling ☐
Itching ☐
Burning ☐
Foreign Body Feeling ☐
Glare/Light Sensitive ☐
Eye Pain/Soreness ☐
Chronic Eye/lid Infections ☐
Styes or Chalazion ☐
Tired Eyes ☐
Mucus Discharge ☐

GASTROINTESTIONAL
Diarrhea ☐
Constipation ☐
GENITOURINARY
Genitals/Kidney/Bladder ☐
HEMATOLOGIC/LYMPH ☐
Anemia ☐
Blood Disorders ☐
INTEGUMENTARY (SKIN) ☐
MUSCLE/JOINT/BONES ☐
Rheumatoid Arthritis ☐
Muscle /Joint Pain ☐
NEUROLOGICAL
Headaches ☐
Migraines ☐
Head Trauma ☐
Seizures ☐
PSYCHIATRIC ☐
RESPIRATORY
Asthma ☐
Chronic Bronchitis ☐
Emphysema ☐
OTHER ☐

If you selected any of the above or have a condition not listed, please explain and list any medications related to that condition:

_____

_____

WELCOME TO THE CLINIC AND THANK YOU FOR CHOOSING US FOR YOUR EYECARE

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