THE VISION AND LEARNING CENTER

MEDICAL QUESTIONNAIRE

(Please Print)

Today's date:				PCP:	
PATIENT INFORMATION					
Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
How would you like to be contacted? ❑ Phone ❑Email	Mother's Maiden Name:	Date of last eye appointment:	Birth date: / /	State of Birth:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
Email:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )	

MEDICAL INFORMATION

Do you have any allergies to medication:

List any medications you are currently taking (Including but not limited to asprin, vitamins, birth control, over the counter medicine):

FAMILY HISTORY- ***PLEASE CIRCLE ALL THAT APPLY***

Disease/ Condition	Please Circle one		Relationship to you
Blindness	**YES**	**NO**	_____
Cataract	**YES**	**NO**	_____
Crossed Eyes	**YES**	**NO**	_____
Glaucoma	**YES**	**NO**	_____
Macular Degeneration	**YES**	**NO**	_____
Retinal Detachment/Disease	**YES**	**NO**	_____
Arthritis	**YES**	**NO**	_____
Cancer	**YES**	**NO**	_____
Diabetes	**YES**	**NO**	_____
Heart Disease	**YES**	**NO**	_____
High Blood Pressure	**YES**	**NO**	_____
Kidney Disease	**YES**	**NO**	_____
Lupus	**YES**	**NO**	_____
Thyroid Disease	**YES**	**NO**	_____

TOBACCO-

NEVER CURRENT USER FORMER USER

ALCOHOL USE-

NEVER RARELY MODERATE DAILY

Please turn sheet over →

REVIEW OF PATIENT SYSTEMS

CIRCLE ANY THAT APPLY TO YOU

Constitutional –	**Endocrine-**
Fevers, weight loss weight Gain	Thyroid or Gland Problems
Integumentary -	Diabetes Type 1 or Type 2
Eczema	**Ear, Nose, Mouth, Throat-**
Shingles	Allergies or Hay Fever
Rosacea	Sinus Congestion
Neurological-	Runny Nose
Headaches	Post Nasal Drip
Migraines	Chronic Cough
Seizures	**Respiratory-**
Eyes-	Asthma
Cataracts	Chronic Bronchitis
Retinal Detachment	Emphysema
Glaucoma	Cystic Fibrosis
Loss of Vision	COPD
Blurred or Distorted Vision	**Vascular / Cardiovascular-**
Double Vision	Heart Pain
Dryness	High Blood Pressure
Mucous Discharge	Vascular Disease
Redness	**Gastrointestinal-**
Sandy or Gritty Feeling	Constipation
Itching	Diarrhea
Burning	**Genitourinary-**
Foreign Body Sensation	Genital / Bladder Problems/Kidney
Excess Tearing or Watering	**Bones, Joints, Muscles**
Glare or Light Sensitivity	Rheumatoid Arthritis
Eye Pain or Soreness	Multiple Sclerosis
Chronic Infections or Sties	**Immunological**
Flashes or Floaters	**Psychiatric**