HOMETOWN EYE CARE

MEDICAL HISTORY

Questionnaire

Signature _____ Date _____

PATIENT INFORMATION

Patient Name			
Date of Birth			
Referring Doctor		Date of Last Eye Exam:	

Do you wear glasses?	☐ YES ☐ NO	Do you wear Contacts ?	☐ YES ☐ NO

Have you ever had any major eye injuries, surgeries, or diseases of the eye? ☐ YES ☐ NO

If YES , please explain:	
Please list all medications: *(including eye drops, birth control, vitamins, etc.)*	

Have you or your family had any of the following conditions or disorders ? Please check:

General	**Self**	**Family**	**Eye Problems**	**Self**	**Family**
Diabetes	[ ]	[ ]	Glaucoma	[ ]	[ ]
Thyroid problems	[ ]	[ ]	Macular Degeneration	[ ]	[ ]
High blood pressure, Heart Disease	[ ]	[ ]	Cataracts	[ ]	[ ]
High Cholesterol, Stroke	[ ]	[ ]	Retinal Detachment	[ ]	[ ]
Asthma, Emphysema or COPD	[ ]	[ ]	Blindness	[ ]	[ ]
Unexplained weight loss/gain	[ ]	[ ]	Lazy Eye	[ ]	[ ]
Ear, nose, mouth, or throat problems	[ ]	[ ]	NONE OF THE ABOVE	[ ]	
Eczema, Psoriasis, or chronic rashes	[ ]	[ ]			
GERD, Ulcers, Intestinal disorders	[ ]	[ ]	**Do you have a history of :**		
Kidney/Urinary or Prostate problems	[ ]	[ ]	Alcohol Abuse	☐ YES	☐ NO
Arthritis or Gout	[ ]	[ ]	Tobacco use	☐ YES	☐ NO
Cancer	[ ]	[ ]	Substance Abuse	☐ YES	☐ NO
Depression / Anxiety	[ ]	[ ]			
NONE OF THE ABOVE	[ ]				

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