VISION INSTITUTE MEDICAL QUESTIONNAIRE

NAME _____ **CHART #** _____ **D.O.B.** _____ **DATE** _____

Please circle "N" if there are no problems in the area described or "Y" if there are problems in the area described and circle any specific problems that follow. Please give details below of when or how long you have had the problem or any treatments given.

Y N **GENERAL HEALTH:** Sudden loss of weight, unexplained fever.

Y N **EYES:** Injury, infection, surgery, glaucoma, double vision, cataract, retinal disease

Y N **EARS, NOSE, THROAT:** Cancer, sinusitis, hearing loss, loss of taste

Y N **CARDIOVASCULAR (heart):** Hypertension, heart attack, congestive heart failure, bypass surgery.

Y N **RESPIRATORY (lungs):** Emphysema, bronchitis, asthma, cancer

Y N **GASTROINTESTINAL (stomach/colon):** Ulcers, chronic diarrhea, cancer, hepatitis, pancreatitis

Y N **GENITOURINARY (kidneys/bladder):** Infection, cancer, renal stones, prostatectomy

Y N **SKIN/BREAST:** Cancer, basal cell carcinoma, skin allergies

Y N **MUSCULOSKELETAL:** Arthritis, cancer, loss of limb

Y N **NEUROLOGICAL:** Stroke, cancer, head injury, loss of sensation, mobility or memory

Y N **HEMATOLOGIC/LYMPHATIC:** Cancer, anemia

Y N **ALLERGIC/IMMUNOLOGIC:** Low WBC count, chemotherapy

Y N **IMMUNO-COMPROMISED:** Lupus, Leukemia, Sarcoidosis, anything affecting the immune system.

Y N **ENDOCRINE:** Diabetic How Long?_____ Blood Sugar:_____
Thyroid: Hyperthyroid, hypothyroid, removed, cancer

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DRUG ALLERGIES _____

CURRENT EYE MEDS/DROPS: CURRENT MEDICATIONS:

1. _____	1. _____	6. _____
2. _____	2. _____	7. _____
3. _____	3. _____	8. _____
4. _____	4. _____	9. _____
5. _____	5. _____	10. _____

MEDICAL & FAMILY HISTORY:
List previous surgeries or major illnesses not mentioned above.

_____

_____

_____

Do any of the following conditions run in your family? (Glaucoma, cataracts, "crossed eyes," blindness, diabetes, macular degeneration) If so, please circle and give specifics below.

_____

_____

SOCIAL HISTORY:
Please list any use or exposure to the following:

Y N Alcohol _____ Y N Occupational chemicals _____

Y N Tobacco _____ Y N Illicit Use of Drugs _____

Y N Other _____

Primary Care Physician (PCP) _____ PCP Phone: _____

Thank you for your time. This information will help us to better serve you.