Medical History Questionnaire

Northern Valley Eyecare, Inc. 50 Bank Street • St. Albans, VT 05478 (802) 524-9561

Name:_____ Today's Date:_____

Address:_____ Phone: (Home):_____

(Work):_____

E-Mail: _____

(Cell):_____

Birth Date:_____ Social Security #:_____/_____/_____

Employer:_____ Occupation:_____ Pharmacy:_____

Physician:_____ Last Medical Exam:_____ Last Eye Exam:_____

Spouse/Guardian:_____ Who referred you to the office: _____

Household Family Members:_____

Eye History

Distance Blur (without Glasses)	❑ Yes ❑ No	Glare Sensitivity	❑ Yes ❑ No
Near Blur (without Glasses)	❑ Yes ❑ No	Light Sensitivity	❑ Yes ❑ No
Flashing Lights in Vision	❑ Yes ❑ No	Eye Pain/Soreness	❑ Yes ❑ No
Floating Spots in Vision	❑ Yes ❑ No	Double Vision	❑ Yes ❑ No
Headaches	❑ Yes ❑ No	Loss of Vision	❑ Yes ❑ No
Itchy Eyes	❑ Yes ❑ No	Known Lazy Eye	❑ Yes ❑ No
Dry/Burning Eyes	❑ Yes ❑ No	Known Glaucoma	❑ Yes ❑ No

General Health

High Blood Pressure	❑ Yes ❑ No	Ears, Nose, Throat	❑ Yes ❑ No
Diabetes (type 1, type 2)	❑ Yes ❑ No	Gastrointestinal	❑ Yes ❑ No
Heart or Circulatory Disease	❑ Yes ❑ No	Kidney, Bladder	❑ Yes ❑ No
Respiratory (asthma)	❑ Yes ❑ No	Skin	❑ Yes ❑ No
Blood, Lymph (cholesterol)	❑ Yes ❑ No	Anxiety, Depression	❑ Yes ❑ No
Joints, Muscles, Bones	❑ Yes ❑ No	Psychiatric	❑ Yes ❑ No
Endocrine (thyroid)	❑ Yes ❑ No	Allergic, Immunologic	❑ Yes ❑ No
Constitution (patient well)	❑ Yes ❑ No	HIV, Hepatitis, Syphilis	❑ Yes ❑ No
Neurological (MS, stroke)	❑ Yes ❑ No	Cancer	❑ Yes ❑ No

Do you smoke? ❑ No ❑ Occasional ❑ Frequent

Do you drink alcohol? ❑ No ❑ Occasional ❑ Frequent

Are you pregnant &/or nursing? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Past Illnesses, Injuries or Surgeries:_____

_____

Known Family History

Glaucoma	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No
Retinal Detachment	❑ Yes ❑ No
Blindness	❑ Yes ❑ No
Lazy Eye or Eye Turn	❑ Yes ❑ No
Macular Degeneration	❑ Yes ❑ No
Color Blindness	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No

Drug Allergies

_____ _____

_____ _____

_____ _____

_____ _____

Medications (Inhalers included)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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_____ _____

_____ _____

_____ _____

List additional medications on back side

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