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):_____

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

Employer:_____ Occupation:_____

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

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

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
Fever, Weight Loss/Gain	❍ 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