

CENTER FOR SIGHT MEDICAL QUESTIONNAIRE

DATE: _____

NAME: _____ **DOB:** _____ **MR #:** _____

CIRCLE "Y" OR "N" FOR EACH OF THE FOLLOWING CATEGORIES, AND CIRCLE ANY CONDITIONS WHICH APPLY.

- Y N **CONSTITUTIONAL:** sudden loss of weight, unexplained fever, abnormal thyroid.
- 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:** high blood pressure, heart attack, congestive heart failure.
- Y N **RESPIRATORY:** emphysema, bronchitis, cancer, asthma.
- Y N **GASTROINTESTINAL:** ulcers, chronic diarrhea, cancer, hepatitis, pancreatitis.
- Y N **GENITOURINARY:** 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, loss of sensation, mobility, memory.
- Y N **HEMATOLOGIC/LYMPHATIC:** cancer, anemia.
- Y N **ALLERGIC/IMMUNOLOGIC:** low WBC count, chemotherapy.
- Y N **DIABETES:** _____ Years

Office Use	
Date	By

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN BELOW. _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

CURRENT OCULAR MEDS

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES _____

FOOD ALLERGIES _____

DRUG ALLERGIES _____

PAST MEDICAL, FAMILY, & SOCIAL HISTORY

- List previous surgeries or major illnesses not mentioned above.

- List any familial conditions of the eye (glaucoma, cataracts, "crossed eyes", blindness)

- Please list any use or exposure to the following:

Y N Alcohol _____ Y N Illicit Use of Drugs _____

Y N Tobacco _____ Y N Other _____

Y N Occupational Chemicals _____