CENTER FOR SIGHT MEDICAL QUESTIONNAIRE **DATE:** _____

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

CIRCLE "Y" OR "N" FOR EACH CATEGORY, 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**

EXPLAIN BELOW IF YOU ANSWERED YES ABOVE.

_____

_____

_____

List names of previous eye doctors, eye surgeries and injuries.

_____

_____

CURRENT MEDICATIONS

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

CURRENT OCULAR MEDS

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

PHARMACY: _____ **LOCATION:** _____ _____ **30 DAY RX** _____ **90 DAY RX**

ALLERGIES _____

FOOD ALLERGIES _____

DRUG ALLERGIES _____

PAST MEDICAL, FAMILY, & SOCIAL HISTORY

List <u>previous surgeries or major illnesses</u> not mentioned above.

_____

_____

List any <u>familial conditions</u> of the eye (glaucoma, cataracts, "crossed eyes", blindness)

_____

_____

Please list any use or exposure to the following:

Y N Alcohol _____
Y N Tobacco _____
Y N Occupational Chemicals _____
Y N Illicit Use of Drugs
Y N Other _____