MEDICAL HISTORY QUESTIONNAIRE
Atchison Eye Center / Franken Eye Clinic

Name: _____ Today's Date: _____/_____/_____

Date of Birth: ____/____/____ Last Eye Exam: ____/____/____ Height: ____ft.____in. Weight_____lbs.

Primary Care Physician: _____Last Medical Exam: ____/____/____

What Pharmacy do you use? _____

Are you interested in new glasses? **Yes** **No** Are you interested in contacts? **Yes** **No**

Medical History

Do you have any allergies to medications? **Yes** **No** If yes, explain: _____

_____

List any medications you take, prescription and over the counter: _____

_____

List all major surgeries and/or hospitalizations you have had: _____

_____

Personal and Family History

Please note anyone (self, parents, grandparents, siblings) who had/has the following conditions:

Disease/Condition							
Blindness	**Yes**	**No**	**?**	Arthritis	**Yes**	**No**	**?**
Cataract	**Yes**	**No**	**?**	Cancer	**Yes**	**No**	**?**
Crossed Eyes	**Yes**	**No**	**?**	Heart Disease	**Yes**	**No**	**?**
Glaucoma	**Yes**	**No**	**?**	High Blood Pressure	**Yes**	**No**	**?**
Macular Degeneration	**Yes**	**No**	**?**	Kidney Disease	**Yes**	**No**	**?**
Retinal Detachment/Disease	**Yes**	**No**	**?**	Lupus	**Yes**	**No**	**?**
Diabetes	**Yes**	**No**	**?**	Thyroid Disease	**Yes**	**No**	**?**

Any Other Medical Conditions: _____

Vision

Does your vision limit any daily activities (driving, reading, work, sports, etc.)? **Yes** **No**

If yes, please describe: _____

Do you have any of the following concerns? Please circle all that apply:

Dryness **Redness** **Itching** **Glare/Light Sensitivity** **Flashes/Floaters** **Tired Eyes**

If you circled any of the above or have a condition not listed, please explain: _____

_____

Social History

Do you use tobacco products? **Yes** **No** If yes, type/amount/how long: _____

Do you drink alcohol? **Yes** **No** If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: _____ Hepatitis _____HIV