THE EYE INSTITUTE OF WYOMING, P.C. MEDICAL HISTORY QUESTIONNAIRE

Date of your last eye exam	NAME			TODAY'	S DA	TE.		
LIST ANY MEDICATION: (INCLUDE ORAL CONTRACEPTIVES, ASPRINS, OTC MEDICATIONS, SUPPLEMENTS, AND HOME REMEDIES) MEDICATION ALLERGIES: Do you wear glasses? Y N How old are your glasses? Do you wear contact lenses? Y N Brand of contacts? How often do you replace your contacts? Are your contacts comfortable? Y N Do you sleep in your contacts? Y N Type of cleaning solution? Brand of contacts comfortable? Y N Do you sleep in your contacts? Y N Type of cleaning solution? Brand of contacts if you have ever had any problems with any of the following areas of your body) CARDIOVASCULAR	Date of your last eye exam			Previous Eye Doctor				
CARDIOVASCULAR	Date of your last medical exam	ı		Current Medical Doctor				
MEDICATION ALLERGIES: Do you wear glasses? Y N How old are your glasses? How often do you replace your contact lenses? Y N Brand of contacts? Are your contacts comfortable? Y N Do you sleep in your contacts? Y N Type of cleaning solution? Review of Systems (Please indicate if you have ever had any problems with any of the following areas of your body) CARDIOVASCULAR Heart Disease/Pain Y N Diarrhea Y N Diarrhea Y N Constipation Y N Genitals Stroke Y N Genitals Y N Genitals Y N Genitals Y N CONSTITUTIONAL Weight Loss/Gain Y N HEMATOLOGIC Chronic Fever Y N Anemia Y N Bleeding Disorders Y N Bleeding Disorders Y N MISCUMENTARY (SKIN) Allergies Y N MISCUMENTARY (SKIN) Sinus Congestion Y N MISCUMENTARY (SKIN) Runny Nose Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Thyroid Y N MUSCLE/JOINT/	LIST ANY MEDICATION	ON	:					
Do you wear glasses? Y N How old are your glasses? Brand of contacts? How often do you replace your contacts? Are your contacts comfortable? Y N Do you sleep in your contacts? Y N Type of cleaning solution? Review of Systems (Please indicate if you have ever had any problems with any of the following areas of your body) CARDIOVASCULAR Heart DiseasePain Y N GASTROINTESTINOL High Blood Pressure Y N GONSTITUTIONAL Stroke Y N GENITOURINARY Vascular Disease Y N GENITOURINARY Vascular Disease Y N GENITOURINARY CONSTITUTIONAL Weight Loss/Gain Y N HEMATOLOGIC Chronic Fever Y N Bleeding Disorders Y N Bleeding Disorders Y N INTEGUMENTARY (SKIN) Sinus Congestion Y N Rash/Eczema Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Chronic Throat Infection Y N MUSCLE/JOINT/BONES Chronic Fever Y N MUSCLE/JOINT/BONES Chronic Fever Y N MUSCLE/JOINT/BONES Chronic Fever Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Chronic Fever Y N MUSCLE/JOI	(INCLUDE ORAL CONTRACEPTIV	 ES, A	ASPR	NS, OTC MEDICATIONS, SUPPLEMENTS, AND HOME REM	EDII	ES)		
Brand of contacts?	MEDICATION ALLERGIES:							
Review of Systems (Please indicate if you have ever had any problems with any of the following areas of your body) CARDIOVASCULAR Heart DiseasePain Y N Diarrhea Y N Constitution Y N GENTIOUNIANAY Vascular Disease Y N GENTIOUNIANAY Vascular Disease Y N GENTIOUNIANAY Weight Loss/Gain Y N HEMATOLOGIC Chronic Fever Y N Bleeding Disorders Y N Bleeding Disorders Y N Sinus Congestion Y N Rash/Eczema Y N Runny Nose Y N MSCLE/JOINT/BONES Chronic Cough Y N MSCLE/JOINT/BONES Chronic Cough Y N MSCLE/JOINT/BONES Chronic Fever Y N MSCLE/JOINT/BONES Chronic Cough Y N MSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Thyroid Y N	Do you wear glasses? Y N l	How	old	nre your glasses? Do you w	ear c	onta	ct lenses? Y N	
Review of Systems (Please indicate if you have ever had any problems with any of the following areas of your body) CARDIOVASCULAR Heart Disease/Pain Y N Diarrhea Y N Stroke Y N Constipation Y N Stroke Y N Genitals Y N Genital	Brand of contacts?		How often do you replace you	How often do you replace your contacts?				
CARDIOVASCULAR	Are your contacts comfortable	? Y	N	Do you sleep in your contacts? Y N Type of clear	ıning	g solı	ution?	
CARDIOVASCULAR								
Heart Disease/Pain Y N	(Please indi	cate	if yo		as of	your	body)	
Heart Disease/Pain Y N	CARDIOVASCULAR			GASTROINTESTINOL				
High Blood Pressure		Y	N .		Y	N		
Vascular Disease Y N Kidney/Bladder Y N Kidney/Blad	High Blood Pressure	Y	N	Constipation	Y	N		
CONSTITUTIONAL Weight Loss/Gain Y N HEMATOLOGIC Chronic Fever Y N Anemia Y N Anemia Y N Allergies Y N INTEGUMENTARY (SKIN) Allergies Y N Rash/Eczema Y N Rash/Eczema Y N Anemia Rash/Ec	Stroke	Y						
Weight Loss/Gain Y N A HEMATOLOGÍC Chronic Fever Y N Baleading Disorders Y N Bleeding Disorders Y N Bunny Nose Y N MUSCLE/JOINT/BONES Arthritis Y N MUSCLE/JOINT/BONES Arthritis Y N MUSCLE/JOINT/BONES W N BURDLOGICAL BURDLO		Y	N .					
Chronic Fever Y N Bleeding Disorders Y N RAILER STREET					Y	N		
EARS, NOSE, MOUTH, THROAT Allergies Y N Sinus Congestion Y N Runny Nose Y N Dry Throat/Mouth Y N Throat Infection Y N Diabetes Y N Hormone Therapy Y N Blurred Vision Y N Double Vision Y N Double Vision Y N Burn/Itch Y N Pain/Discomfort Y N Betagana Bleeding Disorders Y N Muscle/Joint Pain Y N Muscle Pain Aller Pai	Weight Loss/Gain	Y	N.	<u>HEMATOLOGIC</u>				
Allergies Y N INTEGUMENTARY (SKIN) Sinus Congestion Y N Rash/Eczema Y N Runny Nose Y N MUSCLE/JOINT/BONES Chronic Cough Y N MUSCLE/JOINT/BONES Chronic Cough Y N Muscle/Joint Pain Y N Muscle/Joint Pa	Chronic Fever	Y	_N .	Anemia				
Sinus Congestion Y N Runny Nose Y N MUSCLE/JOINT/BONES Chronic Cough Y N Muscle/Joint Pain Y N Muscle/Joint Pa					Y	Ν		
Runny Nose Y N					v	NT		
Chronic Cough Y N Muscle/Joint Pain Y N Musc					1	11		
Dry Throat/Mouth Y N N NEUROLOGICAL Headaches/Migraines Y N NUltiple Sclerosis Y N NUltiple Sclerosis Y N NUltiple Sclerosis Y N NULTANIA NEUROLOGICAL Headaches/Migraines Y N NULTANIA NULTIPLE NULTIP	Chronic Cough	Y	N.	<u>MOSCLE/JOINT/BOINES</u> Arthritis	Y	N		
ENDOCRINE Thyroid Y N Multiple Sclerosis Y N					Y	N		
ENDOCRINE Thyroid Y N Multiple Sclerosis Y N Diabetes Y N Head Trauma Y N Hormone Therapy Y N Seizures Y N EYES Blurred Vision Y N N Nervous Disorders Y N Double Vision Y N N RESPIRATORY Glare/Sensitivity Y N Asthma Y N Burn/Itch Y N Bronchitis Y N Flashes/Floaters Y N Emphysema Y N Pain/Discomfort Y N PREGNANT Y N Redness Y N OTHER Dryness Y N					-	- '		
Thyroid Y N Multiple Sclerosis Y N Diabetes Y N Head Trauma Y N Seizures Seizure			-		s Y	N		
Diabetes Y N Head Trauma Y N Seizures Y N Seizures Y N Seizures Y N Seizures Seizure	Thyroid	Y	N .					
Hormone Therapy	Diabetes		N .	Head Trauma	Y			
EYES PHYCIATRIC Blurred Vision Y N Nervous Disorders Y N Double Vision Y N RESPIRATORY Glare/Sensitivity Y N Asthma Y N Burn/Itch Y N Bronchitis Y N Flashes/Floaters Y N Emphysema Y N Pain/Discomfort Y N PREGNANT Y N Redness Y N OTHER Dryness Y N OTHER		Y	N.	Seizures	Y			
Double Vision Y N RESPIRATORY Glare/Sensitivity Y N				<u>PHYCIATRIC</u>				
Glare/Sensitivity Y N Asthma Y N Burn/Itch Y N Bronchitis Y N Bronchitis Y N Bronchitis Y N Pain/Discomfort Y N PREGNANT Y N OTHER Dryness Y N OTHER					Y	N		
Burn/Itch Y N Bronchitis Y N Flashes/Floaters Y N Emphysema Y N Pain/Discomfort Y N PREGNANT Y N Redness Y N OTHER Dryness Y N								
Flashes/Floaters Y N Emphysema Y N Pain/Discomfort Y N PREGNANT Y N OTHER Dryness Y N								
Pain/Discomfort Y N PREGNANT Y N Redness Y N OTHER Dryness Y N OTHER			N.			IN NT		
Redness Y NOTHER Dryness Y N			N.			IN N		
Dryness Y N					1	IN		
Digness 1 11			N.	OTHER				
Crossed/Lazy Eye Y N			N					

Family History (Parents, Grandparents, Siblings, Children) for the following

DISEASE/CONDITION	RELATIONSHIP TO YOU
Blindness Cataracts Crossed Eyes/ Lazy Eyes Glaucoma Macular Degeneration Retinal Disease Retinal Detachment Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Stroke Thyroid Disease Other:	(Type)
	rial History ally with your doctor during the examination)
ACTIVITY	EXPLAIN
Do you use tobacco products? Do you use alcohol? Do you use illegal substances? Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or	
Do you live alone? Y N Do you drive	e? Y N Any visual difficulty when driving? Y N

Circle activities that you participate in: Shooting/Running/Golf/Tennis/Biking/Sewing/Computer Work