

HEMLER FAMILY EYE CARE
MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date: _____

Eye History:

Date of Last Eye Exam: _____

Last Eye Doctor: _____

Do you have a history of:

	Yes	No		Yes	No
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye (Amblyopia)	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	Any other eye diseases _____		

General Health:

Name of family physician _____

Telephone number: _____

Do you have:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Immune Problems	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
Any other health problems: _____					

Current height _____

Current weight _____

Please list any current medications including dose and frequency: _____

Please list any drug or environmental allergies that you have: _____

Family History:

Does anyone in your family have:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lazy or Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Other eye problems _____					

