Health Questionnaire

EYE CENTER Rx, Inc.

Your Full Name _____ Date of Birth _____

Today's Date _____ Do you wear any of the following? ☐ Glasses ☐ Contacts ☐ No Previous Vision Correction Needed

Primary Care Physician _____ Physician's Telephone _____

Please list any medications, supplements or vitamins you currently are taking. Include prescription and over-the-counter.

_____

_____

Do you have any allergies to medication? ☐ Yes ☐ No List your allergies and the reactions you experience:

_____

List your previous surgeries and the approximate dates. Include any eye surgeries.

_____

_____

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Please check Yes or No if you have been diagnosed with any of the following conditions or have been experiencing any of these symptoms.

OCULAR (EYE)

Glaucoma ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No
Lazy Eye/Eye Turn ☐ Yes ☐ No
Eye Injury ☐ Yes ☐ No
Floating Spots ☐ Yes ☐ No
Flashes of Light ☐ Yes ☐ No
Blurry Vision ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Itching ☐ Yes ☐ No
Tearing ☐ Yes ☐ No
Other _____

CARDIOVASCULAR

Hypertension ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Hardening of Arteries ☐ Yes ☐ No
Other _____

EARS, NOSE, THROAT

Hearing Impaired ☐ Yes ☐ No
Sinusitis ☐ Yes ☐ No
Other _____

SKIN

Itching ☐ Yes ☐ No
New Moles ☐ Yes ☐ No
New Growths ☐ Yes ☐ No
Other _____

BLOOD /LYMPHATIC

Anemia ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No
Other _____

NEUROLOGICAL

Stroke ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Other _____

MUSCULOSKELETAL

Osteoarthritis ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Other _____

ENDOCRINE

Thyroid Disease ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Other _____

RESPIRATORY

Asthma ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Other _____

GENITOURINARY

Kidney Stones ☐ Yes ☐ No
Prostate Cancer ☐ Yes ☐ No
Breast Cancer ☐ Yes ☐ No
Other _____

PSYCHIATRIC

Depression ☐ Yes ☐ No
Panic Attacks ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Other _____

GASTROINTESTINAL

Loss of Appetite ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Other _____

CONSTITUTIONAL SYMPTOMS

Fever ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No
Other _____

Your Tobacco Use: ☐ Never Used Tobacco ☐ Former Smoker (quit _____ years ago) ☐ Current Every Day Smoker (Number of Packs Per Day _____)
☐ Current Occasional Smoker Number of Years Smoking _____ ☐ Current Chewing Tobacco User Number of Years Chewing Tobacco _____

Your Alcohol Use: ☐ Never ☐ Social ☐ 1-2 Drinks Per Day ☐ 3 or More Drinks Per Day

Has any member of your family had any of these diseases? Check all that apply and state which family member.

☐ Blindness _____ ☐ Cataract _____ ☐ Glaucoma _____ ☐ Macular Degeneration _____
☐ Retinal Detachment _____ ☐ Lazy Eye/Eye Turn _____ ☐ Diabetes _____ ☐ Hypertension _____
☐ Heart Disease _____ ☐ Cancer _____ ☐ Thyroid Disease _____ ☐ Stroke _____