Two Rivers Eye Care

Medical Questionnaire

EYE HISTORY

Headaches	O Yes O No	Foreign Body Sensation	O Yes O No	Blurred Vision Distance	O Yes O No
Glare/Light Sensitivity	O Yes O No	Infection of Eye or Lid	O Yes O No	Blurred Vision Near	O Yes O No
Tired Eyes	O Yes O No	Itching	O Yes O No	Distorted Vision (halos)	O Yes O No
Amblyopia (Lazy Eye)	O Yes O No	Mucous Discharge	O Yes O No	Double Vision	O Yes O No
Burning	O Yes O No	Drooping Eyelid	O Yes O No	Floaters or Spots	O Yes O No
Dryness	O Yes O No	Redness	O Yes O No	Fluctuating Vision	O Yes O No
Excess Tearing/Watering	O Yes O No	Sandy or Gritty Feeling	O Yes O No	Loss of Vision	O Yes O No
Eye Pain or Soreness	O Yes O No	Strabismus (Crossed Eyes)	O Yes O No	Loss of Side Vision	O Yes O No
Eye Twitching	O Yes O No				

Other _____

_____

Last eye examination: _____

I am interested in: Glasses Contacts Laser Vision Correction

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

GENERAL HEALTH CONDITION

Fever	O Yes O No	Kidney	O Yes O No
Weight Loss	O Yes O No	Muscles,Bones,Joints	O Yes O No
Other Symptoms	O Yes O No	Skin	O Yes O No
Ears,Nose,Throat	O Yes O No	Neurological (MS)	O Yes O No
High Blood Pressure	O Yes O No	Psychiatric (Anxiety, Depression, Insomnia)	O Yes O No
Respiratory (Asthma)	O Yes O No	Diabetes,thyroid	O Yes O No
Gastrointestinal	O Yes O No	Blood/Lymph (cholesterol)	O Yes O No
		Allergic/Immunologic	O Yes O No

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

Lazy Eye	O Yes O No	Arthritis	O Yes O No
Blindness	O Yes O No	Cancer	O Yes O No
Cataract(s)	O Yes O No	Diabetes	O Yes O No
Color Blindness	O Yes O No	Heart Disease	O Yes O No
Glaucoma	O Yes O No	High Blood Pressure	O Yes O No
Macular Degeneration	O Yes O No	Kidney Disease	O Yes O No
Retinal Detachment	O Yes O No	Lupus	O Yes O No
Eye Turn	O Yes O No	Stroke	O Yes O No
		Thyroid Disease	O Yes O No

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol ? If yes, how much/often : O No O Occasional O 1 per day O 2-3/day O 4+/day

Do you smoke ? If yes, how much/often : O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Hobbies/ Interests : _____

Signature: _____ Date: _____