Columbia River Eye Center

Full Spectrum Eye Care P.S.

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Medical History Questionnaire

Name: _____ Date: _____

Date of birth: _____ Date of last eye exam: _____

List all **MEDICATIONS** you currently take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any medication **ALLERGIES** you have:

_____ _____ _____

_____ _____ _____

List all **MAJOR ILLNESSES** (diabetes, high blood pressure, etc.) or injuries (concussion, etc.):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Circle any problems you are ***currently*** experiencing with your **EYES**

VISION		**DISCOMFORT**	
Glare	Distorted	Dry	Watery
Blurred	Fluctuating	Itching	Redness
Double	Loss of vision	Sandy / Gritty	Discharge

OTHER

Glaucoma	Cataracts
Macular Degeneration	Eye Lid Abnormalities

SOCIAL HISTORY

Current occupation: _____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ☐ YES ☐ NO if YES: occasional 1/day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO if YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? ☐ YES ☐ NO

Do you exercise regularly? ☐ YES ☐ NO

Check any conditions which apply to you

GENERAL HEALTH
- ☐ Fever
- ☐ Weight loss _____lbs.
- ☐ Weight gain _____lbs.

Other _____

GASTROINTESTINAL
- ☐ Ulcer
- ☐ Reflux
- ☐ Irritable Bowel
- ☐ Ulcerative Colitis / Crohn's

Other _____

NEUROLOGICAL
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Parkinson's

Other _____

EARS / NOSE / THROAT
- ☐ Sinus infection
- ☐ Ear infection
- ☐ Chronic cough
- ☐ Dry mouth

Other _____

CANCER
- ☐ Breast
- ☐ Prostate
- ☐ Lung
- ☐ Colon

Other _____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Other _____

CARDIOVASCULAR

Disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attacks

Other _____

Surgery
- ☐ Angioplasty
- ☐ Bypass
- ☐ Valve replacement
- ☐ Carotid Artery

Other _____

URINARY TRACT
- ☐ Kidney problems

Other _____

BLOOD / LYMPH
- ☐ Anemia
- ☐ Hepatitis
- ☐ HIV

Other _____

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid

Other _____

MUSCLES / BONES / JOINTS
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis

Other _____

RESPIRATORY
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ TB

Other _____

SKIN
- ☐ Acne
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Rosacea

Other _____

ALLERGIC / IMMUNOLOGIC
- ☐ Hay fever
- ☐ Lupus
- ☐ Sjogrens

Other _____

FAMILY HISTORY M = Mother F = Father S = Sibling GP = GrandParent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Strabismus / Amblyopia / Lazy eye			
Migraines			
Diabetes			
Heart disease or high blood pressure			
Stroke			
Cancer			
Other			