



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.):

List all previous **SURGERIES** (eye surgeries included):

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

VISION

Glare
Blurred
Double
Distorted
Fluctuating
Loss of vision

DISCOMFORT

Dry
Itching
Sandy / Gritty
Watery
Redness
Discharge

OTHER

Glaucoma
Macular Degeneration
Cataracts
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 1/2 pack/day 1 pack/day 1+ pack/day

Have you ever smoked? YES NO

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 _____

URINARY TRACT

- Kidney problems
- Other _____

ENDOCRINE

- Diabetes
- Thyroid
- Other _____

Surgery

- Angioplasty
- Bypass
- Valve replacement
- Carotid Artery
- Other _____

BLOOD / LYMPH

- Anemia
- Hepatitis
- HIV
- 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 = Sister B = Brother GF = Grandfather GM = Grandmother

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			