Ayers Eye Care, LLC — Medical History Questionnaire

Name:_____ Gender: M / F Today's Date:_____/_____/_____

Address:_____ **Birth Date:_____/_____/_____**

City:_____ State:_____ Zip:_____ Home Phone:_____

Nickname**:** _____ Cell Phone:_____

Occupation/Employer:_____ **E-Mail:**_____

Name of Medical Doctor:_____ Legal Guardian:_____

Emergency Contact:_____ → Phone #:_____

Referred by (circle one): Newspaper Internet Insurance Website Billboard Family/Friend:_____

Social Information: □ Single □ Married □ Separated □ Widowed □ Divorced

Do you: Smoke? □ Yes □ No Drink Alcohol? □ Yes □ No Use Illicit Drugs? □ Yes □ No

Eye History: Have you experienced any of the following?

Allergies (Itchy Eyes)	□ Yes □ No	Eye Injury	□ Yes □ No
Amblyopia (Lazy Eye)	□ Yes □ No	Flashing Lights	□ Yes □ No
Blindness	□ Yes □ No	Floating Spots	□ Yes □ No
Blurred Vision	□ Yes □ No	Glaucoma	□ Yes □ No
Cataract	□ Yes □ No	Macular Degeneration	□ Yes □ No
Double Vision	□ Yes □ No	Retinal Disease/Detachment	□ Yes □ No
Dry Eyes	□ Yes □ No	Strabismus (Eye Turn)	□ Yes □ No
Eye Infection	□ Yes □ No	Surgery	□ Yes □ No

When was your last Eye Exam? _____

Do you wear glasses? □ Yes □ No If yes, how old are they?_____

Do you wear contacts? □ Yes □ No If yes, what kind of solution do you use?_____

Do you wear Sunglasses or Transitions? □ Yes □ No

Family Health History: Have any immediate blood relatives ever had any of the following?

Amblyopia(Lazy Eye)	□ Yes □ No	Relation _____
Blindness	□ Yes □ No	Relation _____
Cancer	□ Yes □ No	Relation _____
Cataract	□ Yes □ No	Relation _____
Diabetes	□ Yes □ No	Relation _____
Glaucoma	□ Yes □ No	Relation _____
Heart Disease	□ Yes □ No	Relation _____
High Blood Pressure	□ Yes □ No	Relation _____
Macular Degeneration	□ Yes □ No	Relation _____
Multiple Sclerosis	□ Yes □ No	Relation _____
Retinal Disease/Detachment	□ Yes □ No	Relation _____
Strabismus	□ Yes □ No	Relation _____
Stroke	□ Yes □ No	Relation _____

(Please turn form over and complete side 2)

Medical Information: How would you describe your overall health?_____

Please list **all** medications:_____

_____

_____

Please list any **allergies to medication**:_____

List any **major** injuries, surgeries or hospitalizations you have had (including eye surgeries like cataract removal, LASIK, etc.)_____

_____

Review of Systems: Do you currently have any significant problems in the following areas?

System	Yes	No	System	Yes	No
ALLERGY			**IMMUNOLOGIC**		
Latex	□	□	AIDS/ HIV	□	□
Environmental	□	□	Lupus	□	□
Seasonal	□	□	Sarcoidosis	□	□
CARDIOVASCULAR			**INTEGUMENTARY (Skin)**		
Anemia	□	□	Acne	□	□
Angina/ Arrhythmia	□	□	Eczema	□	□
Blood Disorder	□	□	Herpes	□	□
Bypass/ Stent	□	□	Rosacea	□	□
Heart Attack	□	□	**MUSKOLOSKELETAL**		
Heart Disease	□	□	Fibromyalgia	□	□
Hypertension	□	□	Muscular Dystrophy	□	□
Stroke	□	□	Osteoarthritis	□	□
Vascular Disease	□	□	Rheumatoid Arthritis	□	□
CONSTITUTIONAL			**NEUROLOGIC**		
Developmental Disability	□	□	Headache	□	□
Fatigue	□	□	Head Injury	□	□
Fever	□	□	Numbness	□	□
Weight Loss	□	□	Multiple Sclerosis	□	□
EAR/NOSE/THROAT			Migraines	□	□
Sinus	□	□	Seizures	□	□
Upper Resp. Infection	□	□	**PSYCHIATRIC**		
Vertigo	□	□	Anxiety	□	□
ENDOCRINE			Depression	□	□
Cholesterol	□	□	Schizophrenia	□	□
Diabetes	□	□	**RESPIRATORY**		
Pituitary	□	□	Asthma	□	□
Thyroid	□	□	Emphysema/COPD	□	□
GI/ URINARY			**Please name/ explain any conditions not listed above:**		
Acid Reflux	□	□	_____		
Bladder	□	□	_____		
Crohn's Disease	□	□	_____		
Hepatitis	□	□	_____		
Kidney	□	□	_____		

Have you ever been diagnosed with any kind of CANCER? Explain:_____

DOCTOR USE ONLY

Reviewed by_____ Date_____

Reviewed by_____ □ No changes Date_____