Tillamook Vision Center Medical History Questionnaire

Patient Name _____ Birthdate _____
Do you currently wear glasses? ___All the time ___Occasionally ___No
Do you wear contact lenses? ___All the time ___Occasionally ___No ___Worn in the past ___Interested in contact lenses
Have you had any eye injuries? Yes / No Describe: _____
Have you had any eye surgeries? Yes / No Describe: _____
Do you drive? Yes / No If yes, do you have visual difficulty driving? Yes / No

Have you been diagnosed with?
Y N Cataract
Y N Macular Degeneration
Y N Glaucoma
Y N Diabetes
Y N Diabetic Retinopathy
Y N Dry Eye
Y N Eye Infection / Inflammation
Y N Floaters and/or Flashes of Light
Y N Iritis or Uveitis
Y N Retina Defects / Degeneration
Other: _____

Do your eyes have:
Y N Redness
Y N Burning
Y N Itching
Y N Tearing
Y N Discharge
Other: _____

Do you have:
Y N Blurred Vision
Y N Eyestrain
Y N Eye Pain
Y N Severe Sensitivity to Light
Y N Headache
Y N Poor Night Vision
Y N Bothersome Night Glare
Y N Double Vision
Y N Total Loss of Vision
Other: _____

Do you use:
Y N Alcohol - How much _____
Y N Tobacco - How much _____

Family History: Circle member affected
F: Father, M: Mother S: Son, D: Daughter

Y N	**Type 2 Diabetes**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Hypertension**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Macular Degeneration**					
	F	**M**	**Bro**	**Sis**	**S**	**D**
Y N	**Glaucoma**					
	F	**M**	**Bro**	**Sis**	**S**	**D**

Do you have the following?
Y: Yes, **N**: No, **P**: Past

Constitutional:
Y N P Fatigue Syndrome
Y N P Cancer – Type: _____

(ENT) Ear Nose Throat:
Y N P Hearing Loss
Y N P Sinusitis
Y N P Dry Mouth
Y N P Laryngitis

Neurological:
Y N P Multiple Sclerosis
Y N P Epilepsy
Y N P Cerebral Palsy
Y N P Tumor
Y N P Migraine

Psychiatric:
Y N P Depression
Y N P Attention Deficit
Y N P Anxiety Disorder
Y N P Bipolar Disorder

Cardiovascular:
Y N P High Blood Pressure
Y N P Stroke / CVA
Y N P Heart Disease
Y N P Vascular Disease
Y N P Congestive Heart Failure

Respiratory:
Y N P Asthma
Y N P Bronchitis
Y N P Emphysema
Y N P Chronic Obstruction
Y N P Sleep Apnea

Gastrointestinal:
Y N P Crohn's Disease
Y N P Colitis
Y N P Ulcer
Y N P Acid Reflux
Y N P Celiac Disease

Genitourinary:
Y N P Kidney Disease
Y N P Prostate Disease / Cancer
Y N P STD
Y N P Benign Prostate Hypertrophy
Y N Pregnant
Y N Nursing
Y N P Herpes
Y N P Chlamydia

Musculoskeletal:
Y N P Osteoarthritis
Y N P Fibromyalgia
Y N P Muscular Dystrophy
Y N P Ankylosing Spondylitis
Y N P Osteoporosis
Y N P Gout

Integumentary:
Y N P Eczema
Y N P Rosacea
Y N P Psoriasis
Y N P Herpes Simplex / Cold Sores
Y N P Herpes Zoster / Shingles

Endocrine:
Y N P Type 2 Diabetes
Y N P Type 1 Diabetes
Y N P Thyroid Dysfunction
Y N P Hormonal Dysfunction

Hematologic / Lymphatic:
Y N P Anemia
Y N P High Cholesterol

Immune:
Y N P Rheumatoid Arthritis
Y N P Lupus
Y N P Sjogren's Syndrome

Allergies:
Y N Drug Allergies List:
_____
Y N Environmental Allergies List:
_____
Other: _____

To the best of my knowledge, I have answered these questions accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any change in my medical status.

_____ -or- _____ _____
Patient Signature Guardian Signature Date

Tillamook
Vision Center

Patient Name: _____ Birthdate: _____

Who is your Primary Doctor?_____
(the provider/PCP/general practitioner you have established care with to see for your general medical needs)

Which Pharmacy do you prefer?_____

Do you take any medications? Yes / No

Patient Medication List: Complete form or bring your pre-printed copy

Medication	Used For	Prescribed By