Medical Health Questionnaire

About Eyes, Inc.
Dr. Leslie R. Dullnig
Therapeutic Optometrist

Appointment Date _____ (PLEASE PRINT)

Patient's Name _____Birth Date _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

YOUR Medical Information:

Who is your MEDICAL DOCTOR? _____

Are you in good health? ❑ Yes ❑ No If NO, explain _____

Do YOU have problems with any of the following systems? If Yes, please check box.

❑ GASTROINTESTINAL
❑ Acid reflux ❑ Other _____
❑ EAR/NOSE/THROAT
❑ Allergies ❑ Dry mouth
❑ Sinus congestion ❑ Other _____
❑ CARDIOVASCULAR
❑ High blood pressure
❑ Heart disease ❑ Other _____
❑ MENTAL / PSYCHIATRIC
❑ NERVOUS SYSTEM
❑ Headaches ❑ Migraine
❑ GENITOURINARY
❑ Kidney/bladder
❑ Other _____
❑ MUSCULOSKELETAL
❑ Rheumatoid arthritis
❑ Muscle/joint pain
❑ INTEGUMENTARY (skin)
❑ RESPIRATORY
❑ Asthma ❑ COPD _____
❑ ENDOCRINE
❑ Diabetes ❑ Thyroid
❑ Other _____
❑ BLOOD/LYMPH
❑ Anemia
❑ Bleeding problems
❑ IMMUNOLOGIC/ALLERGIES

❑ Surgeries (what type and when) _____

❑Other_____

Are you allergic to any drugs/medications? ❑ No ❑ Yes If Yes, please list _____

Name of general physician (your family doctor) _____

Please check Yes or No

Do you smoke? ❑ No ❑ Yes How often/how much? _____

Do you drink alcohol? ❑ No ❑ Yes How often/how much? _____

Do you take any medications? ❑ No ❑ Yes Please list names and dosages _____

_____

Do you use any recreational drugs? ❑ No ❑ Yes

Does anyone in YOUR FAMILY have any of the following? If yes, please check box and list relationship to you.

❑ Diabetes _____ ❑ Glaucoma _____ ❑ High blood pressure _____
❑ Heart Disease _____ ❑ Cancer _____ ❑ Kidney disease _____
❑ Thyroid disease _____ ❑ Glaucoma _____ ❑ Cataracts _____
❑ Macular degeneration _____ Other _____

Do YOU have, or have YOU had any of the following? If yes, please check box, and explain or write comments.

❑ Dry eyes _____ ❑ Eye surgeries _____ ❑ Wear Glasses _____
❑ Blurred Vision – Distance ❑ Eye injuries _____ ❑ Wear Contacts _____
❑ Blurred Vision – Near ❑ Itchy eyes _____ ❑ Floaters _____
❑ Blurred Vision – Arms Length ❑ Burning eyes _____ ❑ Eye Pain _____
❑ Other Eye Symptoms _____

Are you interested in Laser Vision Correction? ❑ Yes ❑ No

Please sign below to indicate that all information above is correct to the best of your knowledge.
Signature _____ Date _____