



# Welcome to Conley Eye Care

We appreciate you taking the time to complete these medical history forms in advance. By doing so, Dr. Conley will be able to spend more time with you during your visit.

We look forward to seeing you soon!

# Medical History Questionnaire



Name:	
Today's Date    /        /	Most Recent Eye Exam        / (mm/yyyy)
Birth Date:        /        /	Age:
Cell Phone Number:	Home Phone:
Email address:	Date of Last Medical Exam:        / (mm/yyyy)
Name of your primary care doctor:	
Reason for last medical exam: <input type="checkbox"/> Routine/Annual <input type="checkbox"/> Other _____	
How should we contact you? <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> US Mail <input type="checkbox"/> Email	
May we leave a message on your home phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
May we leave a message with an adult family member? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list names of the family members with whom we can leave a message:	
May we leave a message with a teenaged family member? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list names of the teenaged family members with whom we can leave a message:	

Are you pregnant and/or nursing:     Yes     No     N/A  
 If yes, what is your estimated date of delivery? \_\_\_\_\_

Have you had a flu shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date _____
Do you have an active cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have an HIV/AIDS diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C

Do you wear Contact Lenses?     Yes     No

If yes, how old are your present lenses?

Type of Contact Lenses:

RGP     Daily Wear     Extended Wear     Bifocal     Monovision     Other

Are the lenses comfortable?     Yes     No    Please list the brand: \_\_\_\_\_



## Medical History Questionnaire

### Current Eye History

**Please tell us the reason for your visit today:**

- Change in vision
- Eye Discomfort (Itching, Tearing, Burning, etc.)
- Difficulty with seeing far away
- Difficulty with seeing up close
- Injury to the eye
- Pain in my  left eye  right eye
- My Primary Care doctor told me to make an appointment
- I am diabetic and was referred by my doctor
- I have a diagnosis of glaucoma and it is time to be seen again
- I have family history of eye problems  Glaucoma  AMD/Macular Degeneration  Other
- Other: \_\_\_\_\_

Do you currently have, or have you had?		Please provide detail if you answer is Yes
Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Near <input type="checkbox"/> Far <input type="checkbox"/> Both
Distorted Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wavy Lines <input type="checkbox"/> Black Spots <input type="checkbox"/> Halos
Loss of Side Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mucous Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sandy or Gritty Feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foreign or Body Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Excess Tearing/Watering	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Glare/Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye Pain or Soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Possible or known Infection Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sty or Chalazion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Floaters/Flashes in Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tired Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been told you might have Glaucoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been told you have a cataract?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Medical History Questionnaire



### Past Medical/Ocular History for Self and Family

In the first two columns: Please indicate if you have any of the following conditions.

In the last three columns: Please note any family history for the following conditions.

<b>Disease/Condition</b>	<b>Check if Yes</b> <input type="checkbox"/>	<b>Treatment(s)</b> <b>(Medicine or Surgery)</b>	<b>Family Member</b> <i>State the relationship (mother, father, child, etc.)</i>	<b>Check if Yes</b> <input type="checkbox"/>	<b>Treatment(s)</b> <b>(Medicine or Surgery)</b>
Blindness	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Cross Eyes/ Strabismus	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Cancer: If yes, list type:	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Lupus	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Depression	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery
Other	<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery		<input type="checkbox"/>	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery





## Medical History Questionnaire

### Medications

Do you have any allergies to medications?  Yes  No If yes, please list:

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Please list all medications you are presently taking and the strength of the medication as well as the number of times per day you take the medication. If you have a list, please present it to be photocopied.

Please include oral contraceptives, aspirin, over-the-counter medications, medical foods, home remedies and/or supplements.

<b>Medications other than Eye Medications</b>	<b>Dose</b>	<b>Number of Times per Day</b>	<b>How long have you been taking this drug?</b>

<b>Eye Medications</b>	<b>Dose</b>	<b>Number of Times per Day</b>	<b>How long have you been taking this drug?</b>

## Medical History Questionnaire



### Review of Systems

Do you currently, or have you had, problems in the following areas:

<b>Constitutional</b>		<b>Vascular/Cardiovascular</b>	
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss/Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Integumentary (Skin)</b>		High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gastrointestinal</b>	
Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Neurological</b>		Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Genitourinary</b>	
Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder/kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Bones/Joints/Muscles</b>	
<b>Endocrine</b>		Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Type 1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Lymphatic/Hematologic</b>	
Diabetes Type 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ears, Nose, Throat</b>		Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies/Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Psychiatric</b>	
Sinus Congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post-Nasal Drip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bipolar	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Throat/Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Respiratory</b>		Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_