# 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

<table>
<tr><td colspan="2">Name:</td></tr>
<tr><td>Today's Date / /</td><td>Most Recent Eye Exam /<br>(mm/yyyy)</td></tr>
<tr><td>Birth Date: / /</td><td>Age:</td></tr>
<tr><td>Cell Phone Number:</td><td>Home Phone:</td></tr>
<tr><td>Email address:</td><td>Date of Last Medical Exam: /<br>(mm/yyyy)</td></tr>
<tr><td colspan="2">Name of your primary care doctor:</td></tr>
<tr><td colspan="2">Reason for last medical exam: ☐ Routine/Annual ☐ Other________________________</td></tr>
<tr><td colspan="2">How should we contact you? ☐ Home Phone ☐ Cell Phone ☐ US Mail ☐ Email</td></tr>
<tr><td colspan="2">May we leave a message on your home phone? ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">May we leave a message with an adult family member? ☐ Yes ☐ No<br>Please list names of the family members with whom we can leave a message:</td></tr>
<tr><td colspan="2">May we leave a message with a teenaged family member? ☐ Yes ☐ No<br>Please list names of the teenage family members with whom we can leave a message:</td></tr>
</table>

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? ☐ **Yes** ☐ **No** Date____________

Do you have an active cough? ☐ **Yes** ☐ **No**

Do you have an HIV/AIDS diagnosis? ☐ **Yes** ☐ **No**

Do you have TB? ☐ **Yes** ☐ **No**

Do you have Hepatitis? ☐ **Yes** ☐ **No** ☐ **A** ☐ **B** ☐ **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 | ☐ **Yes** ☐ **No** | |
| Blurred Vision | ☐ **Yes** ☐ **No** | ☐ Near ☐ Far ☐ Both |
| Distorted Vision | ☐ **Yes** ☐ **No** | ☐ Wavy Lines ☐ Black Spots ☐ Halos |
| Loss of Side Vision | ☐ **Yes** ☐ **No** | |
| Double Vision | ☐ **Yes** ☐ **No** | |
| Dryness | ☐ **Yes** ☐ **No** | |
| Mucous Discharge | ☐ **Yes** ☐ **No** | |
| Redness | ☐ **Yes** ☐ **No** | |
| Sandy or Gritty Feeling | ☐ **Yes** ☐ **No** | |
| Itching | ☐ **Yes** ☐ **No** | |
| Burning | ☐ **Yes** ☐ **No** | |
| Foreign Body Sensation | ☐ **Yes** ☐ **No** | |
| Excess Tearing/Watering | ☐ **Yes** ☐ **No** | |
| Glare/Light Sensitivity | ☐ **Yes** ☐ **No** | |
| Eye Pain or Soreness | ☐ **Yes** ☐ **No** | |
| Possible or known Infection Eye | ☐ **Yes** ☐ **No** | |
| Sty or Chalazion | ☐ **Yes** ☐ **No** | |
| Floaters/Flashes in Vision | ☐ **Yes** ☐ **No** | |
| Tired Eyes | ☐ **Yes** ☐ **No** | |
| Have you been told you might have Glaucoma? | ☐ **Yes** ☐ **No** | |
| Are you a diabetic? | ☐ **Yes** ☐ **No** | |
| Have you been told you have a cataract? | ☐ **Yes** ☐ **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.

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

# Medical History Questionnaire

## Please list any major surgeries and/or hospitalizations

| Surgery | Date | Hospitalization Dates | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Social History

| | | |
|---|---|---|
| Do you use tobacco products? ☐ Yes ☐ No If yes, how often? ☐ Former Smoker | | |
| Do you use recreational drugs? ☐ Yes ☐ No If yes, list the type/amount/how long | | |
| | | |
| Do you drink alcohol? ☐ Yes ☐ No If yes, how often/how much? | | |
| Have you ever been exposed to or infected with: | ☐ Gonorrhea | ☐ Yes ☐ No |
| | ☐ Hepatitis | ☐ Yes ☐ No |
| | ☐ Syphilis | ☐ Yes ☐ No |
| | ☐ Toxoplasmosis | ☐ Yes ☐ No |

What is your occupation? ___________________________________________

How many hours each day do you spend at the computer or electronic devices?

☐ none ☐ 1 to 2 hours ☐ 2.5 to 5 hours ☐ 5.5 to 8 hours ☐ more than 8 hours

Do you play sports? ☐ Yes ☐ No

If yes, which sports do you participate in? ________________________________________

_____________________________________________________________________________

# Medical History Questionnaire

## Medications

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

______________________________________________________________________

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.

| Medications other than Eye Medications | Dose | Number of Times per Day | How long have you been taking this drug? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Eye Medications | Dose | Number of Times per Day | How long have you been taking this drug? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# Medical History Questionnaire

## Review of Systems

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

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

Reviewed by: ______________________________________________ Date: ________________