Oakwood Eye Clinic Medical Questionnaire

Name_____ Age_____ Exam Date_____

Current Address_____

Current Phone number (home)_____(work)_____

Date of last Physical_____ Date of last Eye Exam_____

Physician_____ Last Eye Doctor_____

Email Address_____Cell Phone_____

Medical History

Do you have or have you had:

Diabetes	Yes____	No____	Glaucoma	Yes____	No____
High Blood Pressure	Yes____	No____	Cataracts	Yes____	No____
Thyroid disease	Yes____	No____	Crossed Eyes	Yes____	No____
Heart disease	Yes____	No____	Lazy Eye	Yes____	No____
Bowel Disease	Yes____	No____	Eye Surgery	Yes____	No____
Ulcer	Yes____	No____	Macular Degeneration	Yes____	No____
Lung disease	Yes____	No____	Retinal detachment	Yes____	No____
HIV	Yes____	No____	Floaters	Yes____	No____
Arthritis	Yes____	No____	Color Blindness	Yes____	No____
Head Injury	Yes____	No____	Allergies	Yes____	No____
Cancer	Yes____	No____	Dry eyes	Yes____	No____
Stroke	Yes____	No____	Flashes of Light	Yes____	No____

Eye History

Do you have a History of:

Height_____ Weight_____ Smoker (Y) (N) Drink Alcohol (Y) (N)

Family History: *Does anyone in your family have:*

Glaucoma	Yes____	No____	Detachment	Yes____	No____
Macular Degeneration	Yes____	No____	Diabetes	Yes____	No____

Hospitalizations & Surgeries: Please list with approximate date:

1._____ 2._____

3._____ 4._____

Medications: Please list all Meds including eyedrops (Include Dosage).

1._____ 2._____

3._____ 4._____

Are you Allergic to any medications? _____

So that we may thank them, who referred you to our office?_____

Signed_____ Updated_____Date_____

Updated_____Date_____ Updated_____ Date_____

During your examination: Do not worry about making a mistake or giving the wrong answer.

Do not hesitate to tell the doctor if you are unable to answer his question.