River Region Vision Source
Medical Questionnaire

When was your last eye exam_____ Where_____

Do you currently wear glasses _____ Contact Lenses_____

Are you interested in getting contact lenses_____

Do you work on a computer_____ Do you have trouble with glare_____

Please list any medications you are currently taking or attach a list to this form.
_____
_____
_____
_____
____

Are you allergic to anything:_____

Please list any surgeries you have had along with any eye injuries:
_____
_____
_____

Personal and Family History: Please mark all that apply. (P= Patient F= Family)

	P	F	N/A		P	F	N/A
Cataracts				Arthritis			
Glaucoma				Cancer			
Macular Degeneration				Diabetes			
Lazy Eye or Crossed Eyes				High Blood Pressure			
Retinal Disease				Kidney Disease			
Blindness				Thyroid Disease			

If you answered yes to cancer, what type?_____

Social History: Please mark all that apply.

	Yes	**No**		
Do you drive?			Do you have difficulty driving?	
Do you smoke?			How long/How much?	
Do you use Tobacco?			How long/How much?	
Do you use illegal drugs?			How long/How much/ What Type?	
Do you drink alcohol			How often?	

Review of Systems: Please check Yes or No if you are being treated for any problems related to the areas listed below:

	Yes	**No**		**Yes**	**No**
General Health/ Psychiatric			Respiratory		
Skin/ Integumentary			Cardiovascular		
Neurological			Gastrointestinal		
Eyes			Genitourinary		
Ear/Nose/Throat			Bones/Joints/ Muscles		
Hematologic/ Lymphatic			Endocrine		