Lifestyle & Medical Questionnaire

MOORE FAMILY EYECARE, LLC.
A MEMBER OF VISION SOURCE

Please list the main reason(s) for your visit? _____

YOUR Eye History

List your last EYE Doctor: _____ Last Eye Exam: ____/____/____

Please check any of the following conditions you **currently have or have recently had**.

- □ Cataracts
- □ Glaucoma
- □ Macular Degeneration
- □ Eye Injury
- □ Eye Surgery
- □ Flashes of Light
- □ Dry Eyes
- □ Gritty/Burning
- □ Itchy Eyes
- □ Lazy Eye (Amblyopia – Strabismus)
- □ Retinal Tear/Detachment

Other: _____

YOUR Medical History

List your Medical Doctor: _____ Last Visit: ____/____/_____

Please check any of the following conditions you **currently have or have had in the past**.

- □ High Blood Pressure
- □ Diabetes
- □ Stroke
- □ Heart disease/attack
- □ High Cholesterol
- □ Arthritis
- □ Lupus
- □ Sinus/Allergies
- □ Thyroid
- □ Blood/Lymph
- □ Muscle/Bone
- □ Kidney
- □ STDs
- □ HIV
- □ Seizures
- □ Multiple Sclerosis
- □ Genital/Urinary
- □ Integumentary (Skin)
- □ Respiratory (Lung)
- □ Cancer: _____

Other: _____

YOUR Social History

Please list any medications you take regularly (Rx, over the counter, vitamins, birth control, recreational drugs, etc).

□ NONE _____

_____

Allergies to Medications: □ NONE _____

Tobacco use? □ No □ Yes How much? _____ How long? _____ Do you drink alcohol? □ No □ Yes

FAMILY MEDICAL / EYE History

Please **CIRCLE** the following conditions for your immediate blood relatives (parents and siblings).

- □ Cancer Mom – Dad – Bro – Sis
- □ Diabetes Mom – Dad – Bro – Sis
- □ Hypertension Mom – Dad – Bro – Sis
- □ Thyroid disease Mom – Dad – Bro – Sis
- □ Cataracts Mom – Dad – Bro – Sis
- □ Glaucoma Mom – Dad – Bro – Sis
- □ Macular Degeneration Mom – Dad – Bro – Sis
- □ Lazy Eye (Amblyopia) Mom – Dad – Bro – Sis

□ Other: _____

_____ _____/_____/_____

Signature of Patient or Responsible Party **Date Signed**

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