Family EyeCare of Virginia- Medical History Questionnaire:

Name: _____ Today's Date: _____

Do you wear glasses? Yes No Do you wear contacts? Yes No Interested in contacts? Yes No

When and where was your last eye exam: _____

Are you interested in information about Lasik surgery? Yes No

Do you or any family member currently have or have had any of the following conditions (Please Check ✓)

	Self	Family		Self	Family		Self	Family
Eyes								
Cataract			**Diabetes**			Arthritis		
Glaucoma			Asthma			Muscle Pain		
Lazy Eye			Emphysema			Joint Pain		
Eye Surgery			Bronchitis			Anemia		
Crossed Eyes			Sinus Problems			Ulcers		
Macular Degeneration			Allergies			Herpes		
			Dry Mouth			Lupus		
Systemic			Anxiety			Sarcoid		
Fever			Depression			Tuberculosis		
Skin Rash			Psychiatric Disorder			Gout		
Eczema			**Heart Disease**			Cancer		
Headache			**High Blood Pressure**			HIV		
Migraine			Stroke			Hepatitis		
Seizures			**High Cholesterol**			Syphilis		XXX
Thyroid			Kidney Disease			Gonorrhea		XXX
						Are You Pregnant?	Y N	XXX

Any medical conditions not listed above? _____

If yes to any of the above, please explain: _____

Do you smoke? Yes No Drink Alcohol? Yes No Illegal Drugs? Yes No

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

What is Name of your Primary Care Doctor? _____

Please list all medications you currently take including over-the counter products:

Medication	Dosage	Taken For:	Medication	Dosage	Taken For