STAFF ONLY:
ACCT #:

Gurley Eye Care Associates

# Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Name: _____ Phone: _____ Today's Date: _____

Address: _____ Date of Birth: _____ Gender: _____

Pharmacy: _____

Who is your medical doctor? _____

What is the main reason for your visit today?

_____

_____

**Do you have any of these eye symptoms?**

☐ Blurred distance vision ☐ Glare, halos around lights
☐ Blurred reading vision ☐ Itching or burning eyes
☐ Constant double vision ☐ Eye mattering or tearing
☐ Flashing lights or floaters ☐ Foreign body sensation
☐ Red eyes ☐ Dry eye ☐ Eye pain

**Have you ever had any of these eye problems?**

☐ Cataract ☐ Serious eye injury
☐ Glaucoma ☐ Iritis/uveitis
☐ Macular degeneration ☐ Lazy eye
☐ Wore eye patch as a child ☐ Retinal detachment
Other: _____

**Do you have any allergies to any medications?**

☐ None known ☐ Yes, which ones? (list below)

| Medication Name | What reaction did you have? |
|---|---|
| | |
| | |
| | |
| | |

**Which *eye medications* do you currently take?**

☐ None ☐ Artificial tears

| Medication Name | Amount | How many times/day |
|---|---|---|
| | | 1 2 3 4 at bedtime |
| | | 1 2 3 4 at bedtime |
| | | 1 2 3 4 at bedtime |

**Which *other medications* do you currently take?**

☐ None ☐ Aspirin on a daily basis?

| Medication Name | Amount |
|---|---|
| | |
| | |
| | |
| | |

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**Have you ever had any of these conditions?** ☐ **None**

☐ Stroke ☐ Dizziness ☐ High blood pressure
☐ Arthritis ☐ Allergies ☐ Heart disease
☐ Diabetes ☐ AIDS, HIV ☐ Lung diseases
☐ Cancer ☐ Anemia ☐ Thyroid disease
☐ Migraines ☐ Other: _____

**Have members of your family had any *eye* diseases?**
**(This would be your father, mother, sister, brother, grandparents)**

☐ Diabetic eye disease or diabetes
☐ Glaucoma ☐ Cataract
☐ Retinal detachment ☐ Macular degeneration
☐ Blindness ☐ Poor vision
☐ Iritis/uveitis ☐ Crossed eyes
☐ Other: _____

**Please list any *eye* surgeries you have had:**

☐ None

| Type of Eye Surgery | Which Eye | | Year |
|---|---|---|---|
| | Right | Left | |
| | Right | Left | |
| | Right | Left | |
| | Right | Left | |

**Please list any *other* surgeries you have had:**

☐ None

| Type of Surgery | Year |
|---|---|
| | |
| | |
| | |
| | |

**Smoking History:**

☐ Do not smoke ☐ Current smoker ☐ Former smoker

**If applicable, are you pregnant?**

No _____

Yes _____ Expected date of delivery: _____

**Approximate date of your last eye examination?**

_____

_____

Signature Date

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Signature Date