ACCT #:
STAFF ONLY:

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 medications and/or food?

☐ 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

****USE THE BACK OF THIS PAGE IF YOU NEED MORE SPACE****

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

☐ Stroke ☐ Migraines ☐ High blood pressure
☐ Arthritis ☐ Heart disease ☐ High cholesterol
☐ Diabetes ☐ AIDS, HIV ☐ Lung diseases
☐ Thyroid disease
☐ Cancer ---- **(specify)** _____
☐ 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?

_____

_____