Medical History:

Do you currently have a problem with

SYSTEM	NO	YES
CONSTITUTIONAL		
Cancer	☐	☐
Lyme Disease	☐	☐
Fatigue Syndrome	☐	☐
MUCOSKELETAL		
Arthritis	☐	☐
Macular Dystrophy	☐	☐
Osteoporosis	☐	☐
Fibromyalgia	☐	☐
Gout	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Multiple Sclerosis	☐	☐
Stroke	☐	☐
Tumor	☐	☐
ENDOCRINE		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Thyroid problem	☐	☐
Hormone problem	☐	☐
VASCULAR / CARDIOVASCULAR		
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
EAR/NOSE/THROAT		
Hearing Loss	☐	☐
Sinusitis	☐	☐
ALLERGY/IMMUNOLOGIC		
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogrens Syndrome	☐	☐

SYSTEM	NO	YES
EYES		
Blurred Vision	☐	☐
Burning	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Excess Tearing/Watering	☐	☐
Eye Pain or Soreness	☐	☐
Glare/Light Sensitivity	☐	☐
Itching	☐	☐
Loss of Side (Peripheral) Vision	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Stye or Chalazion	☐	☐
Temporary Loss of Vision	☐	☐
Tired Eyes	☐	☐
Flashes/Floaters in Vision	☐	☐
PSYCHOLOGICAL		
Depression	☐	☐
Anxiety	☐	☐
Attention Deficit Disorder	☐	☐
Bipolar Disorder	☐	☐
INTEGUMENTARY		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Cold Sores	☐	☐
Shingles	☐	☐
GASTROINTESTINAL		
Crohns Disease	☐	☐
Colitis	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐
GENITOURINARY		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Hepatitis	☐	☐
Gonorrhea	☐	☐
HIV	☐	☐
Syphilis	☐	☐
HEMOTOLOGIC/LYMPHATIC		
Anemia	☐	☐

Please list any additional conditions:

Patient Signature: _____ Date: _____

avon eye care

Medical History Questionnaire

Patient Name: _____ Sex: M F DOB: ___/___/___

Address: _____ Home Phone: _____

City: _____ State _____ ZIP: _____ Cell/Work Phone: _____

Social Security #: _____ / ____ / _____ Medical Doctor: _____ Location: _____

List ALL Current Medications (Prescription & Over the Counter) :

_____

_____

_____

Do you have any allergies to medications? ☐NO ☐YES List with Reaction: _____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Ocular History

Have YOU been diagnosed with: ☐Glaucoma ☐ Macular Degeneration ☐Cataracts ☐ Lazy Eye ☐ Crossed Eyes
☐Retinal Disease ☐ Eye Injury

Do you wear glasses ☐NO ☐YES If yes, for what activities? _____

Do you wear contact lenses? ☐NO ☐YES If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐Gas Perm (rigid) ☐ Soft Do you sleep in your contacts? ☐ NO ☐ YES

Name of Contact Lens cleaning solution: _____ Average wear time daily: _____

Name of any eye drops you use: _____

Family History

Please note any family history (parents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	Who	DISEASE/CONDITION	Who
Blindness		Diabetes	
Cataract before age 50		High Blood Pressure	
Crossed Eyes		Cancer	
Glaucoma		Thyroid Disease	
Macular Degeneration			
Retinal Detachment			

Social History

Do you drive? ☐ NO ☐ YES If yes, do you have visual difficulty when driving? ☐ NO ☐YES If yes, please describe:

_____

Do you use tobacco products? ☐ NO ☐ YES If yes, type/amount/how long: _____

Do you drink alcohol? ☐ NO ☐YES If yes, type/amount/how long:_____

Do you use illegal drugs? ☐ NO ☐ YES If yes, type/amount/how long: _____