VisionCare Returning Patient History Questionnaire

Full (Legal) Name: _____ Age: _____

Address_____City/State_____

ZIP Code:_____ Preferred Contact Number:_____

Family Physician_____ Employer_____

Medical Information

1. Current Medications: _____ _____ _____

_____ _____ _____ _____

2. Diabetes: Yes / No ***If yes:*** Type: _____ Date of Diagnosis: _____

Average Sugar Level: _____ Med Dosage: _____

3. Allergies to Medications: _____

Surgeries: _____ Eye Injuries: _____

4. **FAMILY History**: Please check all that apply:

____Diabetes ____High Blood Pressure ____ Glaucoma

____ Cataracts ____ Macular Degeneration

5. Please check all that apply ***FOR YOU:***

___Glaucoma ___Cataracts ___Lazy Eye ___Sudden Vision Loss ___Retinal Problems

___Cigarette Use ___Alcohol Use ___Other Substances: _____

6. Current Health Conditions—Check ALL that apply:

___High Blood Pressure	___Arthritis	___Kidney Disease	___Blood Disorder
___Asthma	___Prostate	___Depression	___Heart Disease
___Anxiety	___Emphysema	___Migraines	___High Cholesterol
___Pregnant	___Stroke	___Multiple Sclerosis	___Ulcers/Reflux
___Seizures	___Cancer	___Thyroid Disorder	___Hearing Disorder
___Skin Disorder	___Water Retention	___Sinus	___Hormone Replacement

Signature: _____ Date: _____