VisionCare Returning Patient History Questionnaire

Full (Legal) Name: _____ Age: _____

Address_____City/State_____

ZIP Code_____ Cell_____

Family Physician_____ Home_____

Employer_____ Email_____

Occupation_____

Medical Information

Current Medications/Supplements: _____

_____

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

Average Sugar Level: _____ Med Dosage: _____

Where would you like us to send a diabetic report?:_____

Allergies to Medications: _____

Surgeries: _____ **Eye Injuries:** _____

PATIENT History – *please check all that apply:*

____Glaucoma ____Lazy Eye ____Cataracts ____Macular Degeneration

____Retinal problems Other_____

____Cigarette Use ____Alcohol Use Other Substances: _____

FAMILY History: *Please check all that apply*:

____Diabetes ____High Blood Pressure ____ Glaucoma ____ Cataracts ____ Macular Degeneration

Other_____

Current Health Conditions - *Please check all that apply:*

___ High Blood Pressure ___ Arthritis ___ Kidney Disease ___ Stroke

___ Heart Disease ___ Depression ___ Prostate ___ Asthma

___ Water Retention ___ Anxiety ___ Blood Disorder ___ Emphysema

___ Hearing Disorder ___ Thyroid Disorder ___ Multiple Sclerosis ___Hormone Replacement

___ Sinus ___ Cancer ___ Migraines ___ Pregnant

___ Skin Disorder ___ Ulcers/reflux ___ Seizures ___High Cholesterol

Other_____

Signature: _____ Date: _____