Medical & Lifestyle Questionnaire

MOORE FAMILY EYECARE, LLC.
A MEMBER OF VISION SOURCE

YOUR Eye History

List your last EYE Doctor: _____ Last Eye Exam: ____/____/____

Please check any of the following conditions you **currently have or have recently had**.

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Flashes of Light
- ☐ Dry Eyes
- ☐ Gritty/Burning
- ☐ Itchy Eyes
- ☐ Lazy Eye (Amblyopia – Strabismus)
- ☐ Retinal Tear/Detachment

Other: _____

YOUR Medical History

List your Medical Doctor: _____ Last Visit: ____/____/_____

Please check any of the following conditions you **currently have or have had in the past**.

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart disease/attack
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Lupus
- ☐ Sinus/Allergies
- ☐ Thyroid
- ☐ Blood/Lymph
- ☐ Muscle/Bone
- ☐ Kidney
- ☐ STDs
- ☐ HIV
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Genital/Urinary
- ☐ Integumentary (Skin)
- ☐ Respiratory (Lung)
- ☐ Cancer: _____

Other: _____

YOUR Social History

Please list any medications and supplements you take regularly (best to provide list with dosage).

☐NONE _____

_____

_____

Allergies to Medications: ☐NONE _____

Tobacco use? ☐No ☐Yes How much? _____ How long? _____ Do you drink alcohol? ☐No ☐Yes

Please **CIRCLE** the following conditions for your immediate blood relatives (parents and siblings).

☐ Cancer	Mom – Dad – Bro – Sis	☐ Cataracts	Mom – Dad – Bro – Sis
☐ Diabetes	Mom – Dad – Bro – Sis	☐ Glaucoma	Mom – Dad – Bro – Sis
☐ Hypertension	Mom – Dad – Bro – Sis	☐ Macular Degeneration	Mom – Dad – Bro – Sis
☐ Thyroid disease	Mom – Dad – Bro – Sis	☐ Lazy Eye (Amblyopia)	Mom – Dad – Bro – Sis

☐ Other: _____

_____ _____/_____/_____

Signature of Patient or Responsible Party **Date Signed**

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