CHEYENNE VISION CLINIC, P.C.
MEDICAL HISTORY QUESTIONNAIRE

Name (Last, First, M)____**Today's D**ate ____________

ARE YOU INTERESTED IN ANY OF THE FOLLOWING: CONTACT LENSES______GLASSES _______
LASER (LASIK) SURGERY______ DRY EYE TREATMENT______OTHER_________________________

Do you wear glasses (how old are they)_________Do you wear contact lenses (how old are they)_________
Type of Contact Lens ___________________Are they comfortable_____ Type of Solution______________

Do you participate in: Shooting __Skiing __Running __Golf __Tennis __Biking __Other ______________________

Date of Last Eye Exam ____________Previous Eye Doctor______________ Pharmacy of Choice_________________
Date of Last Medical (physical) Exam __________________ Medical Doctor _________________________________
List all **major injuries**, surgeries (including eye), and/or **hospitalizations** (including general anesthesia) you had:

____

LIST ANY MEDICATION (S) you take (including contraceptives, aspirin, OTC, supplements, & home remedies):
____

____

MEDICATION ALLERGIES ____

Are you pregnant or nursing _________ Have you recently had a baby (delivery date): _________________________

Family History (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition		Relationship to you
Blindness	☐	________________________
Cataract	☐	________________________
Crossed Eyes/Lazy Eye	☐	________________________
Glaucoma	☐	________________________
Macular Degeneration	☐	________________________
Retinal Detachment	☐	________________________
Retinal Disease	☐	________________________
Arthritis	☐	________________________
Cancer	☐	________________________
Diabetes	☐	________________________
Heart Disease	☐	________________________
High Blood Pressure	☐	________________________
Kidney Disease	☐	________________________
Lupus	☐	________________________
Thyroid Disease	☐	________________________
Other __________________		________________________

Social History (can be discussed directly and confidentially with your Doctor during the examination)
Do you use tobacco products, drink alcohol, or use illegal drugs (explain)_____________________________
Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis____________________
Do you drive____ Do you have trouble seeing when driving, especially at night_________________________
Do you have trouble seeing to read, watch television, walk or perform other daily activities________________
Do you feel safe at home _________. Other ____

Review of Systems

Have you ever had problems with any of the following areas of your body:

SYSTEM (Check Those That Apply and Leave Those That Do Not Apply Blank)

ALLERGY/IMMUNE (20% U.S.) ____
CARDIOVASCULAR ____
Heart Disease/Pain ____
High Blood Pressure (33% U.S.) ____
Stroke (3rd leading cause of death) ____
Vascular Disease ____
CONSTITUTIONAL
Fever, Weight Loss/Gain ____
EARS, NOSE, MOUTH,THROAT
Allergies/Hayfever (20% U.S.) ____
Sinus Congestion ____
Runny Nose/Post-Nasal Drip ____
Chronic Cough ____
Dry Throat/Mouth ____
Chronic Throat Infections ____
ENDOCRINE
Thyroid/Other Glands (10% U.S.) ____
Hormone Replacement Therapy ____
Diabetes (21 million Americans) ____
EYES
Seeing at Night ____
Loss of Vision/Side Vision ____
Blurred Vision/Distortion ____
Halos/Distorted Vision ____
Computer Use (how much) `____
Double Vision ____
Flashes/Spots ____
Lazy Eye (3% of children) ____
Dryness (10 million Americans) ____
Eye Injury ____
Redness ____
Sandy/Gritty Feeling ____
Itching ____
Burning ____
Foreign Body Feeling ____
Glare/Light Sensitive ____
Eye Pain/Soreness ____
Chronic Eye/lid Infections ____
Sties or Chalazion ____
Tired Eyes ____
Mucus Discharge ____

GASTROINTESTIONAL
Diarrhea ____
Constipation ____
GENITOURINARY
Genitals/Kidney/Bladder ____
HEMATOLOGIC/LYMPH ____
Anemia ____
Bleeding Disorders ____
INTEGUMENTARY (SKIN) ____
MUSCLE/JOINT/BONES ____
Arthritis (20 million Americans) ____
Muscle /Joint Pain ____
NEUROLOGICAL
Headaches/Migraines (20% U.S.) ____
MS (½ million Americans) ____
Head Trauma ____
Seizures ____
PSYCHIATRIC (20% U.S. adults) ____
RESPIRATORY ____
Asthma (15 Million Americans) ____
Chronic Bronchitis ____
Emphysema (90% are smokers) ____
OTHER __________________ ____

If you answered YES to any of the above or have a condition not listed, please explain and list any medications related to that condition: ________

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____

____

______________________________ Doctor Signature

________________________________ Date

WELCOME TO THE CLINIC AND THANK YOU FOR CHOOSING US FOR YOUR EYECARE
"LIFE HAS NEVER LOOKED BETTER"

DR. CARROLL DR. LAHIFF DR. WELLS
CHEYENNE VISION CLINIC, P.C.

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307-634-EYES (3937) 307-638-6100

FROM EYE GLASSES AND CONTACT LENSES TO MEDICINE AND EYE INJURIES
WE HAVE ANSWERS TO YOUR VISION NEEDS FOR YO

CHEYENNE VISION CLINIC P.C.
Dr. Carroll Dr. LaHiff Dr. Wells