Vision and Health History

Vision and eye health:

Do you...

.....Work at a computer for long periods of time?	Y / N
.....Do a lot of paperwork, reading or close work?	Y / N
.....Have prescription sunglasses?	Y / N
.....Have problems with glare and reflections?	Y / N
.....Have occasional need or desire to not wear your glasses?	Y / N
.....Currently wear contact lenses?	Y / N
.....Have problems with dry or itchy eyes?	Y / N

Please circle: Do you or have you ever had...

Glaucoma	Y / N	Macular Degeneration	Y / N
Retinal Detachment	Y / N	Eye Surgery	Y / N
Eye Injury	Y / N	Eye Disease	Y / N
Lazy Eye	Y / N	Cataracts	Y / N
Eye Infections	Y / N	Flashes/Floaters	Y / N

Your Medical History: Do you currently have or had any of the following conditions?

Allergic/Immunologic:

Drug Allergy:	Y / N	Environmental Allergy:	Y / N
Rheumatoid Arthritis:	Y / N	Lupus:	Y / N
Arthritis:	Y / N	Other : ______________________	

Cardiovascular:

High Blood Pressure:	Y / N	Mitral Valve Prolapse:	Y / N
Heart Disease:	Y / N	Arrhythmia:	Y / N
Stroke:	Y / N	Heart Murmur:	Y / N
Other : ______________________			

General Health:

Developmental Delays:	Y / N	Headaches:	Y / N
Migraine Headaches:	Y / N	Cancer:	Y / N

Genitourinary:

STD (HIV, Herpes, Chlamydia)	Y / N	Kidney Disease:	Y / N
Prostate Disease:	Y / N	Other : ______________________	

Hematologic/Lymphatic:

Anemia:	Y / N	Sickle Cell Anemia:	Y / N
Leukemia:	Y / N	Other : ______________________	

Dermatologic:

Eczema:	Y / N	Atopic Dermatitis:	Y / N
Psoriasis:	Y / N	Impetigo:	Y / N
Rosacea:	Y / N	Other : ______________________	

2251 North Woodlawn, Wichita, KS 67220
2720 East 21st Street, Wichita, KS 67214
2508 Edgemont Dr. Ste 6, Arkansas City, KS 67005

www.tmseyecare.com

Ear/Nose/Throat

Hearing Loss:	Y / N	Sinusitis:	Y / N
Other : ____________			

Endocrine:

Diabetes:	Y / N	Pituitary Disorder:	Y / N
Thyroid:	Y / N	Gout:	Y / N
Elevated Cholesterol:	Y / N	Other : ____________	

Musculoskeletal:

Multiple Sclerosis:	Y / N	Osteoporosis:	Y / N
Epilepsy:	Y / N	Myasthenia Gravis:	Y / N
Other : ____________			

Psychiatric:

Depression:	Y / N	ADHD:	Y / N
Anxiety Disorder:	Y / N	Autism:	Y / N
Bipolar Disorder:	Y / N	Drug Dependency:	Y / N
Other : ____________			

Respiratory:

Asthma:	Y / N	COPD:	Y / N
Bronchitis:	Y / N	Sarcoidosis:	Y / N
Tuberculosis:	Y / N	Other : ____________	

Neurological:

Bell's Palsy:	Y / N	Cerebral Palsy:	Y / N
Dyslexia:	Y / N	Other : ____________	

Gastrointestinal:

Acid Reflux:	Y / N	Colitis:	Y / N
Inflam. Bowel Disease:	Y / N	Hepatitis:	Y / N
Other : ____________			

Do you use any tobacco products? If so what type and how much? ____________

Do you use any alcohol products? If so what type and how much? ____________

Do you use any narcotics or other illegal drugs? ____________

Are you currently pregnant or breastfeeding? ____________

Who is your Medical Doctor? (name and address) ____________

Are you allergic to any medications? Please list ____________

Are you currently taking any medications, eye drops or supplements? Please List ____________

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Family History: Please circle and list relationship:

Thyroid Disease:	Y / N	____________	Blindness:	Y / N	____________
Cancer:	Y / N	____________	High Blood Pressure:	Y / N	____________
Diabetes:	Y / N	____________	Retinal Detachment:	Y / N	____________
Glaucoma:	Y / N	____________	Heart Disease/Stroke:	Y / N	____________
Cataracts:	Y / N	____________	Macular Degeneration:	Y / N	____________