

**2012 CREATIVE OPTICAL, LLC
MEDICAL QUESTIONNAIRE**

Name _____ Date: _____

Date of **Birth** _____ Date of **last Eye exam** _____
 List any **medications** you currently take (RX and over the counter): _____
 Do you have **allergies** to any medications? **YES NO** If YES, list the medications: _____
 List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries**
 (Concussion, etc.): _____
 List any **surgeries** you have had (cataract, appendectomy): _____

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (Poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
 Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
 Are you interested in Lasik Surgery? **YES NO**
 Have you ever had a blood transfusion? **YES NO**
 Do you drink alcohol? **YES NO** IF YES, how much? _____
 Do you smoke? **YES NO** If YES, how much? _____ How Many Years? _____

Physician's Signature _____ Date _____