

Date: _____
 Name: _____
 Occupation: _____
 Family Doctor: _____
 Previous Eye Doctor: _____

Dr. Carl Ryan and Associates
Medical History Questionnaire

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>
CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Migranes	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR		
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC / IMMUNOLOGIC		
ENDOCRINE			PSYCHIATRIC		
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

<u>FAMILY HISTORY</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>

Others: _____

SOCIAL HISTORY - This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you engage in regular exercise? _____ If yes, how much/often? _____

Do you drink alcohol? _____ If yes, how much/often? _____

Do you use tobacco products? _____ If yes, how much/often? _____