Laconia Eye Associates
Medical History Questionnaire

Name: _____ Date of Birth: _____

Referring Doctor: _____ Date of last eye exam:_____

Do you wear glasses? _____ contacts? _____

Have you ever had any major eye injuries, surgeries or diseases of the eye?_____

If yes, please explain: _____

Please list all medications (including eye drops, birth control, vitamins, etc) :

_____

_____

_____

Allergies to medication: _____

Have you or any members of your family had any of the following conditions or disorders? Please check:

GENERAL:	Self	Family
Diabetes	[ ]	[ ]
Thyroid Problems	[ ]	[ ]
High Blood Pressure, Heart Disease,		
High Cholesterol or Stroke	[ ]	[ ]
Asthma, Emphysema or COPD	[ ]	[ ]
Unexplained weight loss/gain	[ ]	[ ]
Ear, nose, mouth or throat problems	[ ]	[ ]
Eczema, Psoriasis or chronic rashes	[ ]	[ ]
GERD, Ulcers, Intestinal Disorders	[ ]	[ ]
Kidney/Urinary or Prostate problems	[ ]	[ ]
Arthritis or Gout	[ ]	[ ]
Cancer	[ ]	[ ]
Depression/Anxiety	[ ]	[ ]
NONE OF THE ABOVE	[ ]	

EYE PROBLEMS:	Self	Family
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Cataracts	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Blindness	[ ]	[ ]
Lazy Eye	[ ]	[ ]
Other	[ ]	[ ]
NONE OF THE ABOVE	[ ]	

Do you have a history of:

Alcohol Abuse? Yes [ ] No [ ]

Tobacco or Cigarette Use? Yes [ ] No [ ]

Substance Abuse? Yes [ ] No [ ]

Signature: _____ Date: _____