Wagner Family Eyecare
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Date _____ Name of Patient _____ Date of Birth _____

Please answer all of the following questions about your medical status and history:

1. Have you ever been treated for any medical condition (diabetes, high blood pressure, arthritis, etc.)?
   Yes ___ No ___ If yes, please explain: _____
2. Have you ever had any eye disease (glaucoma, cataract, wandering or lazy eye, retinal detachment, etc.)?
   Yes ___ No ___ If yes, please explain: _____
3. Have you ever had ***any*** surgery?
   Yes ___ No ___ If yes, please provide date and reason _____
   _____
4. Have you ever been hospitalized?
   Yes ___ No ___ If yes, please provide date and reason _____
   _____
5. Do you take any medications or vitamins?
   Yes ___ No ___ If yes, please list: _____
6. Do you take any eye medications?
   Yes ___ No ___ If yes, please list: _____
7. Do you have any food or drug allergies?
   Yes ___ No ___ If yes, please list: _____

REVIEW OF SYSTEMS:	***YES***	***NO***	***PLEASE EXPLAIN***
Do you currently have any of the following conditions?			
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (hearing loss, sinus problem, sore throat)	___	___	_____
Heart problems (chest pain, irregular heart beat, etc.)	___	___	_____
Respiratory problems (shortness of breath, wheezing, coughing)	___	___	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	___	___	_____
Urinary problems (pain or discomfort, blood in urine)	___	___	_____
Skin problems (rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	___	___	_____
Neurological problems (numbness, weakness, headaches, paralysis)	___	___	_____
Psychiatric problems (depression, anxiety, panic attacks)	___	___	_____

8. Do any **medical** or **eye diseases** run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?Yes ___ No ___ If yes, please explain:
   _____
   _____
9. Do you smoke? If yes, how much? _____ Do you drink alcohol? If yes, how much? _____
   Do you use any illicit or illegal drugs? If yes, what and how often? _____
10. If employed, how many hours per week do you work? _____
11. Does your employment contribute to any stress in your life? Yes ___ No ___

Physician Signature _____ Date _____