CARABIN EYE CARE
Medicine & Surgery of the Eye

MEDICAL QUESTIONNAIRE / EYE HISTORY

Name: _____ Date: _____
What brings you to our office? _____
Do you wear glasses for vision? _____
Do you wear contact lenses? _____ If so, last time they were changed? _____
Do you have Glaucoma? _____ If so, how is it being treated? _____
Have you had cataract surgery? _____
Right eye? _____ Date of Surgery: _____ Surgeon: _____
Left eye? _____ Date of Surgery: _____ Surgeon: _____
Did you have any other surgery or eye diseases? _____
Right eye? _____ Date of Surgery: _____ Surgeon: _____
Left eye? _____ Date of Surgery: _____ Surgeon: _____
Last eye exam: _____
What did your doctor tell you? _____

MEDICAL - SOCIAL HISTORY

Medical Doctor's Name _____ Address _____
Were you born prematurely? _____
Have you ever suffered from the following (please check yes or no):

	Yes	No		Yes	No
Headaches, sinus, tonsillectomy	____	____	History of psychological disorder	____	____
Heart condition	____	____	Thyroid disease	____	____
High blood pressure	____	____	Diabetes, if yes, how long?	____	____
Circulatory problems	____	____	Bleeding disorder, anemia	____	____
Lung disease	____	____	Aids or infectious disease	____	____
Ulcers, liver, gall bladder	____	____	Cancer (type)	____	____
Kidney, bladder, prostate disease	____	____	Do you smoke?	____	____
Stroke or neurological disorder	____	____	Do you drink?	____	____

Other surgery, illness or hospitalization not noted above? _____
_____
_____
List any medication allergies: _____
_____
_____
List all the medications you are currently taking, please include eye drops: _____
_____
_____

FAMILY HISTORY

Is there any family history of? (If so, please list the relative for the condition):
Cataracts _____
Glaucoma _____
Retinal Disease _____
Diabetes _____
Hypertension _____
Anemia _____
Other eye or systemic disease _____