Milton-Edgewood Eye Clinic, pllc

Eye Health Questionnaire

This information is critical to the evaluation of your vision and health.
Please answer these questions to the best of your ability.

Patient Name: _____ I prefer to be called _____ Age _____
Date of Birth _____

☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Separated
☐ Student (School _____ Grade: _____)
Your Occupation_____
Your Employer_____

Other family members cared for by us _____

Name of person who came with you today _____
Their relationship to you _____

Neighbor or Relative NOT living with you:
Name_____ Relationship_____
Contact #(___)_____

What is the major purpose of this visit? _____

Past **EYE Surgeries** (please list): _____

Tobacco use: ☐ never ☐ quit _____ years ☐ active _____ packs/ day

Alcohol use: ☐ never ☐ quit _____ years ☐ active _____ drinks/ day

Recreational Drug use: ☐ never ☐ quit _____ years ☐ active

Do You:
☐ Y ☐ N experience **fainting spells** or **light-headedness**?
☐ Y ☐ N take **multi-vitamins** on a regular basis?

Please list any **eye drops** you use consistently (or periodically):
_____
_____
_____

Please list below any **medications** you take:
_____
_____
_____
_____
_____
_____

Medical Allergies: _____

Please list your **Medical Doctor** (or Clinic) and any **Specialists** you see on a regular basis:
_____ City _____ Specialty _____
_____ City _____ Specialty _____
_____ City _____ Specialty _____

Patient Signature: _____ Date _____

For Office Use Only

Drs. Initials _____ Date_____