Kueber Eye Care Medical History

Mark All That Apply

Constitution

Developmental Disability ☐
Cancer ☐
Fatigue Syndrome ☐
Other ☐

Ear Nose Throat

Hearing Loss ☐
Sinusitis ☐
Dry Mouth ☐
Laryngitis ☐
Other ☐

Neurological

Multiple Sclerosis ☐
Epilepsy ☐
Cerebral Palsy ☐
Tumor ☐
Migraine ☐
Autism Spectrum Disorder ☐
Other ☐

Psychological

Depression ☐
Attention Deficit ☐
Anxiety Disorder ☐
Bipolar Disorder ☐
Other ☐

Cardiovascular

Hypertension ☐
(High Blood Pressure)
Stroke/CVA ☐
Heart Disease ☐
Vascular Disease ☐
Congestive Heart Failure ☐
Other ☐

Respiratory

Cigarette Smoker ☐
Asthma ☐
Bronchitis ☐
Emphysema ☐
Chronic Obstruction ☐
Sleep Apnea ☐
Other ☐

Gastrointestinal

Crohn's ☐
Colitis ☐
Ulcer ☐
Acid Reflux ☐
Celiac Disease ☐
Other ☐

Genitourinary

Kidney Disease ☐
Prostate Disease ☐
STD ☐
Benign Prostate ☐
Hypertrophy ☐
Pregnant ☐
Nursing ☐
Other ☐

Musculoskeletal

Arthritis ☐
Osteoarthritis ☐
Fibromyalgia ☐
Muscular Dystrophy ☐
Ankylosing Spondylitis ☐
Osteoporosis ☐
Gout ☐
Other ☐

Integumentary

Eczema ☐
Rosacea ☐
Psoriasis ☐
Herpes Simplex ☐
(Cold Sore)
Herpes Zoster ☐
(Shingles)
Other ☐

Endocrine

Type 2 Diabetes ☐
Type 1 Diabetes ☐
Thyroid Dysfunction ☐
Hormonal Dysfunction ☐
Other ☐

Hemotologic/Lymphatic

Anemia ☐
Large Volume Blood Loss ☐
Hypercholesteremia ☐
(High Cholesterol)
Other ☐

Allergic/Immune

Drug Allergies ☐
Environmental Allergies ☐
Food Allergies ☐
Rheumatoid Arthritis ☐
Lupus ☐
Sjogren's Syndrome ☐
HIV/Aids ☐
Other ☐

Eye Health

Cataracts ☐
Macular Degeneration ☐
Glaucoma ☐
Any injury to eye ☐

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IMMEDIATE FAMILY HISTORY

Father = F Mother = M Brother = B Sister = Sis Son = S Daughter = D

□ Cancer	F	M	B	Sis	S	D
□ Diabetes	F	M	B	Sis	S	D
□ Hypertension	F	M	B	Sis	S	D
□ Hyperthyroidism	F	M	B	Sis	S	D
□ Hypothryroidism	F	M	B	Sis	S	D
□ Macular Degeneration	F	M	B	Sis	S	D
□ Cataract	F	M	B	Sis	S	D
□ Glaucoma	F	M	B	Sis	S	D

□Unknown—if adopted

Do you take any medication? Y or N

Do you have problems driving at night? Y or N

Are you color deficient? Y or N

Preferred Pharmacy:_____

Primary Care Physician_____

Best phone number to reach you at:_____

Email address:_____

Preferred method of contact? Call Text Email

Do you have any concerns?_____
_____
_____