Family Eye Care Center

Where the health of your eyes comes first!

Dr. Jeffrey L. Anderson
Dr. Courtney R. Sivertson
Dr. Dessie D. Mason
Dr. Dominic A. Miron
200 14th Street NW
Austin, MN 55912

Name: _____

Preferred name: _____

Occupation: _____

Hobbies: _____

We are asking you to fill out this complete medical history and questionnaire because many diseases and conditions can affect your eyes. All of the information on this form is kept strictly confidential. If you are unable to complete the form on your own, one of our staff members will assist you.

Primary Care Physician: _____ **Pharmacy:** _____

Primary reason for visit: _____

Do you currently wear glasses?..... ☐Y ☐N
if yes, what type? (circle) Readers / Distance / Bifocal / Trifocal / Progressive

Do you currently wear contact lenses?..... ☐Y ☐N
if yes, what type/brand? _____

if no, are you interested in contact lenses?..... ☐Y ☐N

Are you interested in Lasik Eye Surgery?..... ☐Y ☐N

Do you have problems in the following areas? (please circle all that apply)

Loss of vision
Blurred vision
Distorted vision
Double vision
Dryness
Mucous discharge
Difficulties with night vision
Itching/Burning
Redness
Foreign body sensation
Excess watering
Light sensitivity
Eye pain or soreness
Sties or chalazion
Flashes in vision
Floaters in vision
Eye injury explain _____
Glare

Ocular History

Blindness	☐Y	☐N
Glaucoma	☐Y	☐N
Cataract	☐Y	☐N
Macular degeneration	☐Y	☐N
Retinal Detachment	☐Y	☐N
Amblyopia (lazy eye)	☐Y	☐N
Eye turn	☐Y	☐N

Medical History

Arthritis	☐Y	☐N
Asthma	☐Y	☐N
Cancer	☐Y	☐N
Diabetes	☐Y	☐N
Heart disease	☐Y	☐N
Migraines	☐Y	☐N
Thyroid disorder	☐Y	☐N

Elevated cholesterol	☐Y	☐N
High blood pressure	☐Y	☐N
Pregnant	☐Y	☐N
Nursing	☐Y	☐N

Other _____

Are you currently taking any medication..... ☐Y ☐N
if yes, please list all: _____

Are you allergic to any medication or have allergies of any kind?..... ☐Y ☐N
if yes, please list allergy & reaction: _____

Family History (please list relation: parents, maternal/paternal grandparents, siblings)

Blindness	☐Y	☐N	_____	Amblyopia (lazy eye)	☐Y	☐N	_____
Glaucoma	☐Y	☐N	_____	Eye turn	☐Y	☐N	_____
Cataract	☐Y	☐N	_____	Diabetes	☐Y	☐N	_____
Macular degeneration	☐Y	☐N	_____	High blood pressure	☐Y	☐N	_____
Retinal Detachment	☐Y	☐N	_____				

Do you consume alcohol? ☐Y ☐N if yes, amount/how often? _____

Do you use tobacco products? ☐Y ☐N if yes, how long/amount/how often? _____