*NAME:*_____ *DATE:*_____

MEDICAL HISTORY QUESTIONARE/CUESTIONARIO DE SALUD

DO YOU OR YOUR RELATIVES SUFFER FROM ANY OF THE FOLLOWING? PLEASE MARK ALL THAT APPLY: (*SUFRE USTED O SUS FAMILIARES DE ESTAS CONDICIONES*?)

CONDITION (*CONDICION*)	ME (*YO*)	PRESCRIPTION (RECETA USADA)	FAMILY (*FAMILIARES*)
Allergies-medication (Alergias)	( )	_____	( )
Allergies-seasonal	( )	_____	( )
Crossed-eyes (Ojo bizco)	( )	_____	( )
Lazy eye (Ojo vago)	( )	_____	( )
Drooping eyelid (Parpado caido)	( )	_____	( )
Glaucoma	( )	_____	( )
Retinal disease (Dano retina)	( )	_____	( )
Cataracts (Catarata)	( )	_____	( )
Eye infections (Infecciones ojos)	( )	_____	( )
Eye injuries (Heridas ojo)	( )	_____	( )
Macular degeneration (Macula)	( )	_____	( )
Arthritis	( )	_____	( )
Cancer	( )	_____	( )
Diabetes	( )	_____	( )
Heart Disease (Corazon)	( )	_____	( )
Kidney disease (Rinones)	( )	_____	( )
Auto-immune disease	( )	_____	( )
Thyroid disease (Tiroides)	( )	_____	( )
Asthma	( )	_____	( )
High blood pressure (Presion)	( )	_____	( )
Migraines (Migrana)	( )	_____	( )
High cholesterol (Colesterol)	( )	_____	( )

REVIEWED ON
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DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS: PLEASE MARK ALL THAT APPLY: (*HA TENIDO USTED ESTOS PROBLEMAS ALGUNA VEZ?)*

Headaches (Dolor de cabeza)	( )	Seizure (Epilepsia)	( )
Loss of side vision (Perdida vision)	( )	Haloes (Nube)	( )
Double vision (Vision doble)	( )	Dryness(Resequedad)	( )
Mucous discharge (Mucosidad)	( )	Redness (Rojedad)	( )
Gritty sensation (Molestia)	( )	Itching (Escozor)	( )
Burning (Ardor)	( )	Excess tearing (Lagrimeo)	( )
Light sensitivity (Sensitividad a luz)	( )	Eye pain/soreness (Dolor)	( )
Styes/Chalazions (Orzuelo)	( )	Flashes of light (Rayos de luz)	( )
Floaters/Spots (Manchas)	( )	Tired eyes (Vista cansada)	( )
Dry throat/mouth (Sed)	( )	Hay fever (Alergias verano)	( )
Weight loss/gain (Perdida peso)	( )	Skin problems (Piel)	( )
Joint pain (Dolor coyunturas)	( )	Muscle pains (Dolor musculos)	( )

Do you wear glasses? (Usa espejuelos?) ( ) Yes ( ) No
Do you wear contact lenses? (Usa lentillas contacto?) ( ) Yes ( ) No
If so, what type? (De que tipo?) ( ) Soft (Suaves) ( ) Rigid (Rigidos)
Do you sleep with them in? (Duerme con ellos puestos?) ( ) Yes ( ) No
What solutions do you use with your contacts? _____
Do you take birth control pills? (Usa anti-conceptivos?) ( ) Yes ( ) No
Are you pregnant or nursing? (Esta embarazada?) ( ) Yes ( ) No
Do you use tobacco? (Fuma?) ( ) Yes ( ) No
Do you use alcohol? (Bebe alcohol?) ( ) Yes ( ) No
Do you currently use illicit drugs? (Usa drogas ilicitas?) ( ) Yes ( ) No