Mid Columbia Vision Source
Medical History Questionnaire
Dr. Robert Perkins, Dr. Ryan LeBreton, Dr. S. Wes Haynes

Date: _____ Name: _____ DOB: _____

Email Address: _____

Employer: _____ Occupation: _____

Primary Care Provider/Family Doctor: (PCP): _____ PCP's Phone number: _____

Preferred Language: English ☐ Spanish ☐ Other: _____ Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Race (check all that apply): White ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ Other: _____

Reason for Visit:

_____

Check the following conditions that apply to you:

	Yes	No
General		
Cancer	☐	☐
Headache	☐	☐
Ear/ Nose/ Throat		
Sinus Condition	☐	☐
Hearing Loss	☐	☐
Dry Mouth	☐	☐
Neurologic		
Migraines	☐	☐
Epilepsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Multiple Sclerosis	☐	☐
Cerebral Palsy	☐	☐
Psychologic		
ADD/ ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory		
Bronchitis	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Yes	No
Gastrointestinal (digestive)		
Colitis	☐	☐
Crohn's Disease	☐	☐
Celiac Disease	☐	☐
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Integumentary (skin)		
Rosacea	☐	☐
Shingles (zoster)	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Cold sores (simplex)	☐	☐
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Blood Disorders		
Anemia	☐	☐
High Cholesterol	☐	☐
Allergic Conditions		
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren's Syndrome	☐	☐

Females Only: Are you currently pregnant or nursing? **Yes** ☐ **No** ☐

Medication Names and Dosages:

_____

_____

Medication Allergies:

_____

Are you a current smoker?: Yes ☐ No ☐ Former ☐ Do you drink alcohol? Yes ☐ No ☐

Weight: _____ Height: _____

Personal Ocular History:

Condition	**Yes**	**No**	**Right or Left eye**
Cataract			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Eye Surgery			
Floaters/flashes of light			

Other eye conditions or concerns: _____

Family Medial History:

Condition	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
Cancer						
Diabetes						
High Blood Pressure						

Family Ocular History:

Condition	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**
Cataract						
Macular Degeneration						
Glaucoma