GREEN LIGHT ACADEMY

STUDENT MEDICAL QUESTIONNAIRE 2015

Please answer these questions as completely as you can. We realize that this form is long, but the information in this form will be extremely valuable to us in providing you the best possible care if needed.

STUDENT INFORMATION

First Name ____ Last Name ____ M.I ____

Date of Birth (mm/dd/yyyy) ____

Home Address ____

Race/Ethnicity ____

City ____ State ____ Zip Code ____

Gender: Male / Female

Social Security Number ____

Driver's License Number ____

Student Home Phone ____

EMERGENCY CONTACT INFORMATION

First Name ____ Last Name ____

Parent Cell Phone ____

Home Address ____

Relationship to Student ____

INSURANCE COVERAGE

Provider ____

Policy Number ____

ID Number ____

PRIMARY CARE PROVIDER

Name ____

Type of Provider
(eg Pediatrician, Nurse Practioner) ____

Phone Number ____

E-mail ____

Address of Primary Care Provider

City State Zip Code

SPECIALISTS / OTHER CARE PROVIDERS

Name

Specialty

Phone Number

Name

Specialty

Phone Number

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.) in chronological order, if possible. (Do not include eye conditions)

Condition

Month/Year of Diagnosis

Condition

Month/Year of Diagnosis

Condition

Month/Year of Diagnosis

Condition

Month/Year of Diagnosis

Condition

Month/Year of Diagnosis

Condition

Month/Year of Diagnosis

SURGICAL PROCEDURES

Procedure

Month/Year

Procedure

Month/Year

Procedure ________ Month/Year ________

Procedure ________ Month/Year ________

Procedure ________ Month/Year ________

Procedure ________ Month/Year ________

MEDICATIONS

Please list all medications that your are currently taking and their dosage (if known):

Medication and Dose	How long have you been taking it?	No. of times per day

Are you taking aspirin or any other over-the-counter medicines? Yes No

If yes, list:

Do you have any known drug allergies? Yes No

If yes, list:

Who give you your medication? Myself Other:

Special Instructions (include ANY information you would like our staff or doctor to know):

EYE HISTORY

List all eye diseases / conditions that your have, and indicate how long you have had them.

Right Eye Conditions	Month/Year of Diagnosis	Left Eye Conditions	Month/Year of Diagnosis

EYE SURGERY

Have you had surgery on your eyes? No Yes, if so, list:

Right Eye Conditions	Month/Year	Left Eye Conditions	Month/Year

EYE MEDICATIONS

What prescription and over-the-counter eye medicines are you using? Please indicate which eye, the number of times per day, and the duration that you have been using each drop, ointment, or oral medication.

Medication	Eye	How long have you been taking it?	No. of times per day
	Right Eye / Left Eye		
	Right Eye / Left Eye		
	Right Eye / Left Eye		
	Right Eye / Left Eye		

Do you wear glasses? Yes No

If yes, for how long: Date last changed:

Do you wear contacts? Yes No

If yes, for how long: Date last changed:

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

General
- Fever
- Unexplained weight loss Night sweats
- Ear, nose, or throat Ringing in ears Hearing loss
- Pain

Nervous System
- Headache
- Stroke
- Seizure / epilepsy
- Weakness, numbness, tingling

Heart or circulatory problems
- Heart attack or heart failure Irregular heart rhythm
- Chest pain
- Pacemaker Hypertension

Endocrine
- Thyroid disease
- Diabetes
- Hormonal disease

Allergy / immunology
- Environmental allergies Iodine allergy
- Contrast material (dye) allergy
- Cat scratch or cat bite

Skin / breast
- Masses / tumors
- Rash
- Discharge from breast

Lungs / breathing
- Breathing difficulty
- Asthma
- Lung disease

Digestive system
- Diarrhea
- Ulcer disease
- Hepatitis
- Genitourinary

Kidney disease
- Urinary tract infection
- Urinary bleeding
- Altered menses

Blood
- Anemia (low blood count)
- Blood tumors / disease
- Swollen glands
- Bleeding disorder

Musculoskeletal
- Joint pain / arthritis Fractured bones
- Pain with chewing
- Scalp pain or tenderness

Psychiatric
- Depression
- Mood swings
- Anxiety
- Admission to hospital for psychiatric illness

Other:

PERSONAL HISTORY

Do you or have you ever used alcohol? Yes No

If yes, how much:

Do you or have you ever smoked? Yes No

If yes, when did you start?:

How much do you smoke each day?
(if you have quit, when did you stop?)

Do you or have you ever used drugs? Yes No

If yes, how much and what type:

DIET

If you are on a special diet, please describe below:

FAMILY MEDICAL HISTORY

Does anyone in your family have any eye diseases? If so, what is their relationship to you and what type of eye disease do they have?

Condition	Relationship

Condition ________ Relationship ________

Condition ________ Relationship ________

Condition ________ Relationship ________

Condition ________ Relationship ________

Condition ________ Relationship ________

Condition ________ Relationship ________

THANK YOU SO MUCH FOR YOUR HELP!