I have reviewed both sides of this questionnaire with patient

For Clinic Use Only

Date	Tech/MD Initials	Date	Tech/MD Initials
_____	_____/_____	_____	_____/_____
_____	_____/_____	_____	_____/_____

YOUR PHYSICIAN WOULD LIKE TO PROVIDE YOU WITH THE HIGHEST QUALITY CARE POSSIBLE. TO ASSIST HIM/HER, WE ASK THAT YOU COMPLETE THE FOLLOWING HEALTH HISTORY SO THAT YOUR OVERALL HEALTH MAY BE ASSESSED AND INCORPORATED INTO YOUR EYE CARE.

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Sex: M [ ] F [ ] DOB:**_____ **Today's Date:** _____

Current EYE Problem: _____

Drug Allergies: _____

Are You On Blood Thinners? Yes [ ] No [ ] If YES, Which? _____

Who is your Family Physician? _____

What is your pharmacy name, address and phone number? _____

YOUR MEDICATIONS

List All Medications you take, including Over-The-Counter medicines and vitamins/supplements:

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Do You Have a Problem With:	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Skin Disease	___	___	_____	Diabetes/Sugar	___	___	_____
Head (Headaches)	___	___	_____	Cancer	___	___	_____
Ear/Nose/Throat/Mouth	___	___	_____	Cholesterol	___	___	_____
Lungs/Breathing(TB/Asthma)	___	___	_____	Thyroid	___	___	_____
Heart Disease	___	___	_____	Allergies (Environmental)	___	___	_____
High Blood Pressure	___	___	_____	Allergies (Food)	___	___	_____
Stomach/Intestines	___	___	_____	Kidney Stones	___	___	_____
Genitals/Kidney/Bladder	___	___	_____	Urinary	___	___	_____
Arthritis	___	___	_____	Bleeding Disorder	___	___	_____
Bones/Joints/Muscles	___	___	_____	Blood (HIV/Hepatitis)	___	___	_____
Neuro/Stroke	___	___	_____	Infectious Disease	___	___	_____
Lymph Nodes/Swelling	___	___	_____	Psychiatric	___	___	_____

Other Problems: Please List: _____

Treatment _____

OPERATIONS

List any previous operations, general and eye related	Date	Complications or Difficulties
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please Complete Back Of Form!

Family History and Visual Inventory

Your Eye History...

Right	Left		Right	Left	
____	____	Amblyopia (lazy eye)	____	____	Muscle Disorder
____	____	Cataract	____	____	Lacrimal Obstruction
____	____	Corneal Transplant	____	____	Macular Degeneration
____	____	Diabetic Retinopathy	____	____	Retinal Detachment
____	____	Glaucoma	____	____	Iritis
____	____	Eye Injury, please provide date _____		Describe: _____	

List all eye medications you use (including over-the-counter meds):

_____, _____, _____, _____

Have you ever worn glasses or contact lenses? Yes [ ] No [ ] How old is your prescription? _____

Your Family History...

Do/did any family members have?

	Yes	No	Father	Mother	Brother/Sister	Other, explain
Blindness	___	___	_____	_____	_____	_____
Cataract	___	___	_____	_____	_____	_____
Glaucoma	___	___	_____	_____	_____	_____
Macular Degeneration	___	___	_____	_____	_____	_____
Strabismus (crossed eye)	___	___	_____	_____	_____	_____
Diabetes	___	___	_____	_____	_____	_____
Heart Disease	___	___	_____	_____	_____	_____
High Blood Pressure	___	___	_____	_____	_____	_____
Thyroid Disease	___	___	_____	_____	_____	_____

Visual Inventory...

With your glasses or contact lenses on, do you have any problems:

	Yes	No		Yes	No
Reading the Newspaper	___	___	Cooking	___	___
Reading Books	___	___	Working	___	___
Reading Telephone Books	___	___	Writing	___	___
Reading the Mail	___	___	Sewing	___	___
Reading in the daytime	___	___	Watching TV	___	___
With glare from the sun	___	___	With Hobbies	___	___
Driving at night	___	___	Using the Computer	___	___
With glare fron headlights	___	___	Seeing to Walk	___	___

Social History...

		Yes	No		Yes	No
Marital Status: S M W D	Live alone?	___	___	Nursing Home	___	___
Do you?	Smoke?	___	___	Chew Tobacco	___	___
	Use Drugs?	___	___	Drink Alcohol	___	___