EYE CARE
Physicians & Surgeons PC

158 Front Royal Pike, Suite 303, Winchester, VA 22602
(800) 381-1186 Toll free
(540) 409-5254 Phone
(540) 409-5253 Fax

This is a confidential survey. Please respond to all questions by circling the proper answer.

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|---|
| Patient name: |
| Street address: |
| City, state and zip code: |
| Telephone number: (  ) |
| |
| Referring physician: |
| Street address: |
| City, state and zip code |
| Physicians telephone number: (  ) |

Family history:

These questions refer to your grandparents, parents, aunt(s), uncle(s), brother(s), sister(s), children and grandchildren.

| Has anyone in your family ever had any of the following? | | |
|---|---|---|
| Cancer | yes | no |
| Diabetes | yes | no |
| Allergies | yes | no |
| Arthritis or Rheumatism | yes | no |
| Syphilis | yes | no |
| Tuberculosis | yes | no |
| Sickle cell disease or trait | yes | no |
| Lyme disease | yes | no |
| Gout | yes | no |

Date  MD Signature

Has anyone in your family had any of the medical problems listed below?

| | | |
|---|---|---|
| Eyes | yes | no |
| Skin | yes | no |
| Kidneys | yes | no |
| Lungs | yes | no |
| Stomach or bowel | yes | no |
| Nervous system or brain | yes | no |

Social history:

Age (years): Current Job:

| | | |
|---|---|---|
| Have you lived outside of the USA? | yes | no |
| If yes, where? | yes | no |
| Have you ever owned a dog? | yes | no |
| Have you ever owned a cat? | yes | no |
| Have you ever eaten raw meat or uncooked sausage? | yes | no |
| Have you ever had unpasteurized milk or cheese? | yes | no |
| Have you ever exposed to sick animals? | yes | no |
| Do you drink untreated stream, well or lake water? | yes | no |
| Do you smoke cigarettes? | yes | no |
| Have you ever used intravenous drugs? | yes | no |
| Have you ever had bisexual or homosexual relationships? | yes | no |
| Have you ever taken birth control pills? | yes | no |

Personal medical history:

| | | |
|---|---|---|
| Are you allergic to any medications? | yes | no |
| If yes, which medications? | | |
| | | |
| | | |

Please list the current medications that you are currently taking, including non-prescriptions drugs such as aspirin, Advil, antihistamines, etc.

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Past medical history:

Please list all eye operations you have had (including laser surgery), and the dates of the surgery

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Please list all other operations that you have had and the dates of the surgeries.

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Have you ever been told that you have the following conditions?

| | | |
|---|---|---|
| Anemia (low blood count) | yes | no |
| Cancer | yes | no |
| Diabetes | yes | no |
| Hepatitis | yes | no |
| High blood pressure | yes | no |
| Pleurisy | yes | no |
| Pneumonia | yes | no |
| Ulcers | yes | no |
| Herpes (cold sores) | yes | no |
| Chicken pox | yes | no |
| Shingles (Zoster) | yes | no |
| German measles (Rubella) | yes | no |
| Mumps | yes | no |
| Chlamydia or Trachoma | yes | no |
| Syphilis | yes | no |
| Gonorrhea | yes | no |
| Any other sexually transmitted disease | yes | no |
| Tuberculosis (TB) | yes | no |
| Leprosy | yes | no |
| Leptospirosis | yes | no |
| Lyme Disease | yes | no |
| Histoplasmosis | yes | no |
| Candida or moniliasis | yes | no |
| Coccidiomycosis | yes | no |
| Sporotrichosis | yes | no |
| Toxoplasmosis | yes | no |
| Toxocariasis | yes | no |

| | | |
|---|---|---|
| Cysticercosis | yes | no |
| Trichinosis | yes | no |
| Whipple's disease | yes | no |
| AIDS | yes | no |
| Hay fever | yes | no |
| Allergies | yes | no |
| Vasculitis | yes | no |
| Arthritis | yes | no |
| Rheumatoid Arthritis | yes | no |
| Lupus (Systematic Lupus Erythematosus) | yes | no |
| Scleroderma | yes | no |

| Have you ever had any of the following illness? | | |
|---|---|---|
| Reiter's Syndrome | yes | no |
| Colitis | yes | no |
| Crohn's disease | yes | no |
| Ulcerative Colitis | yes | no |
| Adamantiades-Behcet's disease | yes | no |
| Sarcoidosis | yes | no |
| Ankylosing Spondylitis | yes | no |
| Erythema Nodosa | yes | no |
| Temporal Arteritis | yes | no |
| Multiple Sclerosis | yes | no |
| Serpiginous Choroiditis | yes | no |
| Fuchs' Heterchronic IridocyclitisVogt-Koyanagi-Harada Syndrome | yes | no |

Have you ever had any of the following symptoms in the past year?

| General Health: | | |
|---|---|---|
| Chills | yes | no |
| Night sweats | yes | no |
| Fatigue (tire easily) | yes | no |
| Poor appetite | yes | no |
| Unexplained weight loss | yes | no |
| Do you feel sick? | yes | no |

HEAD:

| | | |
|---|---|---|
| Frequent or severe headaches | yes | no |
| Fainting | yes | no |
| Numbness or tingling in your body | yes | no |
| Paralysis in parts of your body | yes | no |
| Seizures or convulsions | yes | no |

EARS:

| | | |
|---|---|---|
| Hard of hearing or deafness | yes | no |
| Ringing or noises in your ear | yes | no |
| Frequent or severe ear infections | yes | no |
| Painful or swollen ear lobes | yes | no |

NOSE AND THROAT:

| | | |
|---|---|---|
| Sores in your nose or mouth | yes | no |
| Severe or recurrent nosebleeds | yes | no |
| Frequent sneezing | yes | no |
| Sinus trouble | yes | no |
| Persistent hoarseness | yes | no |
| Tooth or gum infection | yes | no |

SKIN:

| | | |
|---|---|---|
| Rashes | yes | no |
| Skin sores | yes | no |
| Sunburn easily (photosensitivity) | yes | no |
| White patches of skin or hair | yes | no |
| Loss of hair | yes | no |
| Tick or insect bites | yes | no |
| Painfully cold fingers | yes | no |
| Severe itching | yes | no |

RESPIRATORY:

| | | |
|---|---|---|
| Severe or frequent colds | yes | no |
| Constant coughing | yes | no |
| Coughing up blood | yes | no |
| Recent flu or viral infections | yes | no |
| Wheezing or asthma attacks | yes | no |
| Difficulty breathing | yes | no |

Have you ever had any of the following symptoms:

CARDIOVASCULAR:

| | | |
|---|---|---|
| Chest pain | yes | no |
| Shortness of breath | yes | no |
| Swelling of your legs | yes | no |

BLOOD:

| | | |
|---|---|---|
| Frequent or easy bruising | yes | no |
| Frequent or easy bleeding | yes | no |

GASTROINTESTINAL:

| | | |
|---|---|---|
| Trouble swallowing | yes | no |
| Diarrhea | yes | no |
| Bloody stools | yes | no |
| Stomach ulcers | yes | no |
| Jaundice or yellow skin | yes | no |

BONES AND JOINTS:

| | | |
|---|---|---|
| Stiff joints | yes | no |
| Painful or swollen joints | yes | no |
| Stiff lower back | yes | no |
| Back pain while sleeping or awakening | yes | no |
| Muscle aches | yes | no |

GENITOURINARY:

| | | |
|---|---|---|
| Kidney problems | yes | no |
| Bladder trouble | yes | no |
| Blood in your urine | yes | no |
| Urinary discharge | yes | no |
| Genital sore or ulcers | yes | no |
| Prostatitis | yes | no |
| Testicular pain | yes | no |

| | | |
|---|---|---|
| Are you pregnant? | yes | no |
| Do you plan to be pregnant in the future? | yes | no |