

Eye Associates - Medical History Questionnaire

Name _____ Birth Date _____

Name of physician referring you: _____

Do you wear glasses (circle) YES or NO If YES, how long have you had the current pair: _____

Do you wear contacts (circle) YES or NO If YES, how long have you had the current pair: _____

Do you have an interest in LASIK/Laser Vision Correction? YES or NO

List any medications, including eye drops, which you take: _____

List any vitamins, nutritional supplements, or herbs that you take: _____

Do you have (circle) DIABETES / HEART DISEASE / HIGH BLOOD PRESSURE

List all major illnesses and injuries (dates): _____

List surgeries you have had: _____

Allergies to medications or foods (circle): Sulfa drugs / Fluorescein Dye / Iodine / Penicillin

If others, please list: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes," provide additional information.

Constitutional Symptoms:	NO	YES	Explanation of problem:
Fever	_____	_____	_____
Weight Loss	_____	_____	_____
Fatigue	_____	_____	_____
Eyes:			
Loss of vision	_____	_____	_____
Blurred vision (halos)	_____	_____	_____
Loss of side vision	_____	_____	_____
Double vision	_____	_____	_____
Dryness	_____	_____	_____
Mucous discharge	_____	_____	_____
Redness	_____	_____	_____
Sandy or gritty feeling	_____	_____	_____
Itching	_____	_____	_____
Burning	_____	_____	_____
Foreign body sensation	_____	_____	_____
Excess tearing, watering	_____	_____	_____
Occasional tearing	_____	_____	_____
Glare/light sensitivity	_____	_____	_____
Eye pain or soreness	_____	_____	_____
Chronic eye/lid infection	_____	_____	_____
Stye or chalazion	_____	_____	_____
Fluctuating visual acuity	_____	_____	_____
Ears, nose, mouth, throat:			
Sinus congestion	_____	_____	_____
Runny nose/post nasal drip	_____	_____	_____
Chronic cough	_____	_____	_____
Dry/sore throat or mouth	_____	_____	_____
Respiratory:			
Shortness of breath/cough	_____	_____	_____

	NO	YES	Explanation of problem:
Cardiovascular:			
Heart failure/attack (MI)	_____	_____	_____
Irregular heartbeat	_____	_____	_____
Gastrointestinal:			
Ulcers/heartburn/diarrhea/vomiting	_____	_____	_____
Urinary:			
Pain/discomfort, blood in urine	_____	_____	_____
Musculoskeletal:			
Muscle/joint pain	_____	_____	_____
Skin:			
Rashes/dryness/moles/cancer	_____	_____	_____
Neurological:			
Numbness, weakness	_____	_____	_____
Migraine headaches	_____	_____	_____
Stroke (CVA) or paralysis	_____	_____	_____
Endocrine:			
Heat or cold intolerance/diabetes	_____	_____	_____
Hematological/Lymphatic:			
Bleeding/bruising	_____	_____	_____
Swollen lymph nodes	_____	_____	_____
Allergic/Immunologic:			
HIV or AIDS	_____	_____	_____
Allergy symptoms	_____	_____	_____
Sneezing/itching rashes	_____	_____	_____
Psychiatric:			
Depression/anxiety	_____	_____	_____

FAMILY HISTORY

Blindness	_____	_____	_____
Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular degeneration	_____	_____	_____
Retinal detachment	_____	_____	_____
Arthritis	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Kidney disease	_____	_____	_____
Lupus	_____	_____	_____
Sjogren's disease	_____	_____	_____
Stroke	_____	_____	_____
Thyroid disease	_____	_____	_____
Tuberculosis	_____	_____	_____
Other	_____	_____	_____

SOCIAL HISTORY

Do you drive?	_____	_____	_____
Difficulty with driving?	_____	_____	_____
Problems with night vision?	_____	_____	_____
Do you drink alcohol?	_____	_____	# drinks per week: _____
Do you smoke?	_____	_____	# packs per day: _____
Have you had a blood transfusion?	_____	_____	_____
Have you ever been treated or exposed to an infectious disease: Hepatitis A B C / HIV / AIDS / Syphilis	_____	_____	_____

SIGNATURE _____ **DATE** _____