ADVANCED EYE MEDICAL HISTORY QUESTIONNAIRE

____

Patient's Full Name   Date of Birth   Today's Date

____

Please list reason(s) for your exam today

____

How did you hear about us?

Medical Doctor_________________________
Occupation:___________________________
Marital Status:_________________________

ILLNESSES- Please mark any that you have had:

❑ DiabetesOnset: ______________
❑ High Blood Pressure
❑ Stroke
❑ Heart Attack   Date: ______________
❑ Heart Failure
❑ Heart Rhythm Problem
❑ Arthritis
❑ Asthma

❑ Cancer
❑ Hepatitis
❑ Thyroid
❑ Glaucoma
❑ Please list any others:
____
____
____

MEDICATIONS - List any that you take:
____
____
____
____
____
____

(Office use only)
Date Medications Updated
____
____
____
____
____

Allergies to Medications: ❑ Yes   ❑ No
If Yes, please list: ____

Do you drink alcohol?   ❑YES ❑NO How many glasses/day?_____________
Do you smoke?   ❑ YES ❑NO How many packs/day? _____________

SURGERIES AND/OR HOSPITALIZATIONS and the reason for them:
____
____

more>>>

EYE SURGERIES AND/OR INJURIES (please list type and date)

____

____

Do any family members have any problems with the following?

			RELATIONSHIP TO PATIENT
Blindness	❑YES	❑NO	________________________
Cataracts	❑YES	❑NO	________________________
Glaucoma	❑YES	❑NO	________________________
Macular Degeneration	❑YES	❑NO	________________________
Retinal Detachment	❑YES	❑NO	________________________
Arthritis	❑YES	❑NO	________________________
Cancer	❑YES	❑NO	________________________
Diabetes	❑YES	❑NO	________________________
High Blood Pressure	❑YES	❑NO	________________________
Kidney Disease	❑YES	❑NO	________________________
Stroke	❑YES	❑NO	________________________
Thyroid Disease	❑YES	❑NO	________________________
Other	❑YES	❑NO	________________________

Do you presently have any problems in the following areas?

			EXPLANATION OF PROBLEM
Integument (skin)	❑YES	❑NO	________________________
Head	❑YES	❑NO	________________________
Eyes	❑YES	❑NO	________________________
Ears, nose, mouth, throat	❑YES	❑NO	________________________
Neck	❑YES	❑NO	________________________
Respiratory (lungs/breathing)	❑YES	❑NO	________________________
Cardiovascular (heart/blood vessels)	❑YES	❑NO	________________________
Gastrointestinal (stomach/intestines)	❑YES	❑NO	________________________
Genitourinary (genitals/kidney/bladder)	❑YES	❑NO	________________________
Bones, joints, muscles	❑YES	❑NO	________________________
Neurological system	❑YES	❑NO	________________________
Lymphatic (lymph nodes/swelling)	❑YES	❑NO	________________________
Hematopoietic (blood)	❑YES	❑NO	________________________
Allergic, immunologic	❑YES	❑NO	________________________
Psychiatric	❑YES	❑NO	________________________

Would you be interested in more information on vision correction procedures? ❑YES ❑NO

HISTORY REVIEWED

Physician's Signature ______________________________ Date: ____________________