MEDICAL HISTORY QUESTIONNAIRE

Date: _____ Date Rec'd _____ Reviewed by_____

Patient Name: _____ Date of Birth: _____

Name of doctor that is referring you to us: _____

Your primary complaint: _____

_____

Please list any previous eye problems or surgery: _____

_____

Please list any eye drop(s) you are currently using:

_____ _____ _____

Review of Systems

Do you presently have any problems in the following areas? PLEASE CIRCLE CURRENT CONDITION

General, Constitutional:	fever / weight loss / weight gain / unusually tired / decrease appetite
Skin:	rash / dandruff
Ears, Nose, Mouth, Throat:	hard of hearing / ear pain / dry mouth / cough / difficulty swallowing / sinus problem
Lungs:	congestion / wheezing / shortness of breath
Heart condition:	irregular heart rhythm / slurred speech / paralysis / numbness / swelling of feet
Endocrine:	bulging eyes / excessive thirst / excessive urination
Stomach/Intestines:	stomach upset / heartburn / constipation / diarrhea / jaundice
Kidney/Bladder:	painful urination / frequent urination
Bones, Joints, Muscles:	joint pain / stiffness / arthritis
Neurological (Stroke):	numbness / headache / slurred speech
Hematologic / Lymph:	bleeding problem / poor immunity / anemic
Psychiatric	anxiety / insomnia / depression
Allergic / Immunity:	swollen glands / itching / hives / sneezing

Diabetes? Type I -OR - Type II

Do you take insulin? Yes No Type? _____

High blood pressure Yes No

Cancer Yes No Type?_____

High Cholesterol Yes No

Have you ever been diagnosed with:

Retinal Detachment? Yes No Which eye? RT LT

Macular Degeneration? Yes No

Glaucoma? Yes No

Please list any surgery you have had and the date(s) of this surgery: _____

_____

_____

Do you have allergies to any medications? Yes No If yes, please list medications:

_____

Do you smoke? Yes No If yes, how many packs a day? _____

Do you drink alcohol? Yes No If yes, how many glasses a day? _____