MEDICAL HISTORY QUESTIONNAIRE

Name____Date______________

Date of last eye exam__________________ Date of last physical exam__________________

Name of primary care physician___________________

List of current medications (prescription and over-the-counter):

1)_________________2) _________________3) _________________4) _________________

Do you have allergies to medications? □ YES □ NO

If YES, please list the medications:

1)_________________2) _________________3) _________________4) _________________

Please list all major illnesses (stroke, cancer, diabetes, high blood pressure, etc) and injuries:

1)_________________2) _________________3) _________________4) _________________

Please list all major ocular/eye conditions you have/had (cataracts, glaucoma, retinal detachment, etc):

1)_________________2) _________________3) _________________4) _________________

Please list any medical or ocular surgeries you have had (heart surgery, cataract surgery):

1)_________________2) _________________3) _________________4) _________________

What is your reason for today's visit:

Do you **currently** have any problems in the following areas?
If "YES", please provide information.

REVIEW OF SYSTEMS:	YES	NO	EXPLANATION OF PROBLEM
Allergic/Immunologic (hayfever, lupus, HIV, etc)			
Cardiovascular (heart attack, hypertension, etc)			
Endocrine (diabetes, hypothyroid, etc)			
Gastrointestinal (stomach ulcers, intestine, etc)			
Genital, Kidney, Bladder			
Ears, Nose, Throat (sinus infection, cough, etc)			
Blood/Lymph (high cholesterol, anemia, etc)			
Skin (acne, warts, skin cancer, etc)			
Muscles, Bones, Joints (arthritis, etc)			
Neurological (stroke, multiple sclerosis, etc)			
Psychiatric (anxiety, depression, insomnia, etc)			
Respiratory (asthma, emphysema, etc)			

Continue on back →

FAMILY HISTORY	YES	NO	RELATIONSHIP TO PATIENT (YOU)
Blindness			
Glaucoma			
Other ocular/eye conditions (please describe):			
Cancer (please specify type)			
Diabetes			
Heart disease			
High blood pressure			
Thyroid disease			
Other systemic conditions (please describe):			

Social History

Current Occupation (if retired, former occupation):_____________________________________

Education (High school, vocational school, college, etc):___________________________________

Hobbies/Interests:____

With whom do you live?:____

Have you ever tried to wear contact lenses? □ YES □ NO

Do you currently wear contact lenses? □ YES □ NO

Date/year you were first prescribed contact lenses? ____________

Do you currently wear glasses? □ YES □ NO

If YES, how long have you worn the current prescription? ____________

Tobacco use: □ None □ Former smoker □ <1pack/day □ 1-2 packs/day □ >2 packs/day

Alcohol use: □ None □ Social use only □ 1-2 drinks daily □ Above average use □ Alcohol Dependence

Narcotic use: □ None □ Recreational use □ Chemical dependence

Have you ever had a blood transfusion? □ YES □ NO

Are you pregnant? □ YES □ NO □ N/A

Are you nursing? □ YES □ NO □ N/A

Patient's Signature : ____ Date: ________________

Physician's Signature: ____ Date: ________________

DILATION AND RETINAL PHOTOS

Dilation

Dilating your pupils with eye drops is an essential part of checking the health of the eyes. Without these eye drops, only a small part of the retina can be seen and retinal problems may be missed. Although the effects of this procedure can last for up to six hours and cause some increased problems with glare and clear focusing for your eyes, we do recommend you have this done. We also recommend you have someone with you who can drive you home afterwards. There is no extra cost for this procedure.

Retinal photos

The digital retinal imaging system takes photos of the retina (the back of your eye) after dilation. These photos are saved into your medical records and allow the doctor to observe even the smallest amount of changes when compared to previous photos. The doctor strongly recommends that all patients have this procedure performed. Should you elect to have retinal photos taken, the cost is $39.

I have read and understood this form and will consult further with the doctor if needed.

Name (Printed)____

Signature ____ Date _________

Parent/Guardian____ Date _________