M DICAL HISTORY QUESTIONNAI

For new patients, established patients who may be having a new problem, or our patients whom we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please leave blank. If you are experiencing any of the symptoms listed, PLEASE CHECK THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians.

Date:_____

Full Name: _____ Age:_____ Date of Birth: _____

Street _____ City _____ State _____ Zip _____

Phone Number _____ Cell Number _____ Social Security Number _____

Phone Number and Name of Person to contact if you are not available _____

Medical Doctor _____

Mother's Name (if under 18) _____ Date of Birth _____

Father's Name (if under 18) _____ Date of Birth _____

Employment History: (if child, give parents)

Employer _____

Address _____

Phone Number _____

Referred By _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Do you have any of these symptoms?

❑ Blurred distance vision
❑ Blurred reading vision
❑ Constant double vision
❑ Flashing lights or floaters
❑ Red Eyes ❑ Dry Eye
❑ Glare, halos around lights
❑ Itching or burning eyes
❑ Eye mattering or tearing
❑ Foreign body sensation
❑ Eye Pain

Do you wear glasses or contacts? ❑ Yes ❑ No

Do you have any allergies to any medications?

❑ None known ❑ Yes, which ones? (List below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____

Which eye medications do you currently take?

(Including over the counter)

❑ None ❑ Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which other medications do you currently take?

❑ None ❑ Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

_____
Date

Have you ever had any of these conditions?

❑ None
❑ Stroke ❑ Dizziness ❑ High blood pressure
❑ Arthritis ❑ Allergies ❑ Heart disease
❑ Diabetes ❑ AIDS, HIV ❑ Lung disease
❑ Cancer ❑ Anemia ❑ Thyroid disease
❑ Headaches ❑ Other:_____

Have members of your family had any eye diseases?

(This would be your father, mother, sister, brother, grandparents)

❑ Glaucoma ❑ Diabetic eye disease or diabetes
❑ Cataract ❑ Crossed eyes ❑ Poor Vision
❑ Iritis/uveitis ❑ Blindness ❑ Retinal detachment
❑ Macular Degeneration ❑ Other:_____

Have you ever had any of these eye problems?

❑ Cataract ❑ Serious eye injury
❑ Glaucoma ❑ Iritis / Uveitus
❑ Macular degeneration ❑ Lazy eye
❑ Wore eye patch as a child ❑ Retinal detachment
❑ Other:_____

Do you or have you ever smoked? ❑ Yes ❑ No

Packs per day_____ Age started_____ Age Quit_____

Do you drink Alcohol? ❑ Yes ❑ No

Average drinks per day/week_____

Authorization: I hereby authorize payment directly to the doctor.

It is the policy of this office for payment to be made at the time services are rendered.

_____
Patient Signature