Medical History Questionnaire

Chart:

EYE PHYSICIAN ASSOCIATES S.C.

Name: _____

DOB: _____ Age: _____ Gender: _____

Date: _____ Office: _____

Ocular History

Please list previous eye diseases/ diagnoses/injuries/surgeries	Which Eye(s)?	What was the treatment/surgery?	Approximate date of diagnosis

Visual Function Questions

Please indicate if you are experiencing any difficulty with the following:

Visual Function/Problems	Yes/No	Visual Function/Problems	Yes/No
Reading small print (newspaper, book, phone)	☐ Yes ☐ No	Reading traffic signs, street signs	☐ Yes ☐ No
Glare/Halo (please describe)	☐ Yes ☐ No	Doing fine handiwork	☐ Yes ☐ No
Dry, Red, Sandy and/or itchy feeling	☐ Yes ☐ No	Watching TV, Reading Computer	☐ Yes ☐ No
Difficulty driving on bright sunny days	☐ Yes ☐ No	Are you satisfied with your current vision?	☐ Yes ☐ No
		Difficulty driving at night	☐ Yes ☐ No

Any other visual function problems? If so, please describe:

Visual Aids

Do you wear Glasses? ☐ Yes ☐ No **Do you wear Contact Lenses?** ☐ Yes ☐ No

Other

Do you drive? ☐ Yes ☐ No

Medical History *(please indicate below conditions you have now or have ever had)*

Cardiovascular	☐ Yes ☐ No	Angina / Congestive Heart Failure / High Blood Pressure / High Cholesterol Heart Attack (MI) / Arrhythmia / Other _____
Musculoskeletal	☐ Yes ☐ No	Arthritis / Osteoporosis / Other _____
Ears, Nose, Throat, Mouth	☐ Yes ☐ No	Hearing Impaired / Dry Throat Mouth / Sinus Problems / Other _____
Neurological	☐ Yes ☐ No	Multiple Sclerosis / Stroke / Parkinson's / Fainting / Dizzy Spells Seizure Disorders / Mental Retardation / Alzheimer's / Headaches Other _____
Hematological/Lymphatic	☐ Yes ☐ No	Sickle Cell / Anemia / Other _____
Constitutional Symptoms	☐ Yes ☐ No	Fever / Weight Loss / Weight Gain / Other _____
Respiratory	☐ Yes ☐ No	Emphysema / Asthma / Pulmonary Disease (COPD) / Other _____
Endocrine	☐ Yes ☐ No	Diabetes / Thyroid Disease / Other _____
Allergic/Immunologic	☐ Yes ☐ No	Allergies / Hayfever / Lupus / HIV / AIDS / Other
Genitourinary	☐ Yes ☐ No	Dialysis / Prostate Problems / Other _____
Integumentary	☐ Yes ☐ No	Acne / Rosacea / Eczema / Other _____
Gastrointestinal	☐ Yes ☐ No	Diarrhea / Constipation / Ulcers / Liver Disease / Other _____
Psychiatric	☐ Yes ☐ No	Depression / Anxiety / Other _____
Other Medical Problems	☐ Yes ☐ No	List:

Other Health Information:

Allergies *(Please list all medication allergies & reactions)*

☐ Check here if you ***do not*** have any allergies/reactions

Allergy	Reaction	Allergy	Reaction

History of Latex Allergy? ☐ Yes ☐ No

Have you or any family member(s) had an anesthesia reaction? ☐ Yes ☐ No