Health History Questionnaire

Please fill out this questionnaire as thoroughly as possible. This information will assist us in caring for your vision and eyes. All information given is confidential. If you are unable to fill out this form please inform the front desk for assistance.

Patients Name:_____**Date of Birth**:_____ **Today's Date**:_____

Primary Care Doctor:_____**When was your last medical exam?**_____

When was your eye last exam? _____**Occupation:**_____

Do you currently have any problems in the following areas?

□ Blurred Vision	□ Flashes of Light	□ Itchy Eyes	□ Eye Pain
□ Poor Night Vision	□ Double Vision	□ Burning	□ Drooping Eyelid
□ Spots in Vision	□ Red Eyes	□ Something in eye	□ Eye Turning

If you marked yes to any of the above then please describe:_____

_____

Please list any prior surgeries: _____

_____

Do you have any immediate family members with the following conditions? Please indicate who in your family has the condition.

□ Diabetes:_____	□ Cataracts:_____
□ High Blood Pressure:_____	□ Macular Degeneration:_____
□ Stroke:_____	□ Lazy Eye:_____
□ Blindness:_____	□ Glaucoma:_____

Please list <u>all</u> medications you are currently taking (prescription and over-the-counter)?
□None _____

_____

_____

Do you have any allergies to medications (if YES, please list all medications to which you have allergies and the reaction you have)? □ NO □ YES_____

_____

Do you currently use any of the following:

Tobacco: □ NO □ YES Alcohol: □ NO □ YES Narcotics: □ NO □ YES

Do you Wear Glasses? □ NO □ YES (□Distance □Near □Bifocal)

Do you Wear Contact Lenses? □ NO □ YES **Brand**:_____

Are you interested in trying Contact Lenses today? □ NO □ YES

Please turn this page over and complete the comprehensive medical history. This is an important part of our comprehensive examination. Thank You.

Cardiovascular

Yes/No Angina
Yes/No Arrhythmia
Yes/No Arteriosclerosis
Yes/No Cardiovascular Disease
Yes/No Coagulation Disorder
Yes/No Congestive Heart Disease
Yes/No Elevated Cholesterol
Yes/No Heart Murmur
Yes/No Hypertension
Yes/No Heart Attack (MI)

Constitutional

Yes/No Increased Appetite
Yes/No Decreased Appetite
Yes/No Anemia
Yes/No Cough
Yes/No Constipation
Yes/No Disorientation
Yes/No Fatigue
Yes/No Fever
Yes/No Nausea
Yes/No Increase Thirst
Yes/No Increased Urination
Yes/No Vomiting
Yes/No Weight Gain
Yes/No Weight Loss

Endocrine

Yes/No Crohn's Disease
Yes/No Diabetes Mellitus
Yes/No Diabetic Retinopathy
Yes/No Diabetic Suspect
Yes/No Gout
Yes/No Hyperthyroid
Yes/No Hypoglycemia
Yes/No Thyroid Disorder

Gastrointestinal

Yes/No Acid Reflux
Yes/No Alcoholism
Yes/No Anorexia/Bulimia
Yes/No Cancer
Yes/No Diverticulitis
Yes/No Gallbladder Disease
Yes/No Hepatitis
Yes/No Inflammatory Bowel
Yes/No Ulcer

Head

Yes/No Headache
Yes/No Cluster HA
Yes/No Migraine HA
Yes/No Head Cold
Yes/No Hearing Loss

Hematologic/Lymphatic

Yes/No Bleeding Disorder
Yes/No Anemia
Yes/No Leukemia

Immunologic

Yes/No AIDS
Yes/No Herpes Simplex
Yes/No Herpes Zoster
Yes/No Histoplasmosis
Yes/No HIV (+)
Yes/No Lyme Disease
Yes/No Mononucleosis
Yes/No Sarcoidosis
Yes/No Sjogrens Disease

Integumentary

Yes/No Rosacea
Yes/No Albinism
Yes/No Atopic Dermatitis
Yes/No Basal Cell Carcinoma
Yes/No Lupus

Musculoskeletal

Yes/No Ankylosing Spondylitis
Yes/No Arthritis
Yes/No Rheumatoid Arthritis
Yes/No Down's Syndrome
Yes/No Marfan's Syndrome
Yes/No Myasthenia Gravis
Yes/No Osteoporosis

Neurologic

Yes/No Bells Palsy
Yes/No Brain Tumor
Yes/No Cerebral Palsy
Yes/No Epilepsy
Yes/No Multiple Sclerosis
Yes/No Nystagmus
Yes/No Seizure Disorder
Yes/No Vertigo

Psychiatric Disorder

Yes/No Attention Deficit Disorder
Yes/No Alzheimer's Disease
Yes/No Anxiety
Yes/No Autism
Yes/No Bipolar Disorder
Yes/No Dementia
Yes/No Depression
Yes/No Learning Disorder

Respiratory

Yes/No Asthma
Yes/No Bronchitis
Yes/No Lung Cancer
Yes/No COPD
Yes/No Cystic Fibrosis
Yes/No Emphysema

If you have any other pertinent medical history not included in this form please use this space to write in any details.