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**:_____

Referring Physician:_____ **When was your last medical Exam?**_____

When was your eye last exam? _____ **Primary Care Physician**_____

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	□ Foreign Body Sensation	□ 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 all 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 □ Alcohol □ Narcotics

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

Do you Wear Contact Lenses? □ NO □ YES (□Soft □Toric □Gas Perm □Bifocal)

Are you interested in Contact Lenses? □ NO □ YES

Please Turn Over

ONLY MARK BOXES FOR POSITIVE PERSONAL HISTORY

Cardiovascular

- □ Angina
- □ Arrhythmia
- □ Arteriosclerosis
- □ Cardiovascular Disease
- □ Coagulation Disorder
- □ Congestive Heart Disease
- □ Elevated Cholesterol
- □ Heart Murmur
- □ High Blood Pressure
- □ Heart Attack (MI)

Constitutional

- □ Increased Appetite
- □ Decreased Appetite
- □ Anemia
- □ Cough
- □ Constipation
- □ Disorientation
- □ Fatigue
- □ Fever
- □ Nausea
- □ Increase Thirst
- □ Increased Urination
- □ Vomiting
- □ Weight Gain
- □ Weight Loss

Endocrine

- □ Crohn's Disease
- □ Diabetes Mellitus
- □ Diabetic Retinopathy
- □ Diabetic Suspect
- □ Gout
- □ Hyperthyroid
- □ Hypoglycemia
- □ Thyroid Disorder

Gastrointestinal

- □ Acid Reflux
- □ Alcoholism
- □ Anorexia/Bulimia
- □ Cancer
- □ Diverticulitis
- □ Gallbladder Disease
- □ Hepatitis
- □ Inflammatory Bowel
- □ Ulcer

Head

- □ Headache
- □ Cluster HA
- □ Migraine HA
- □ Head Cold
- □ Hearing Loss

Hematologic/Lymphatic

- □ Bleeding Disorder
- □ Anemia
- □ Leukemia

Immunologic

- □ AIDS
- □ Herpes Simplex
- □ Herpes Zoster
- □ Histoplasmosis
- □ HIV (+)
- □ Lyme Disease
- □ Mononucleosis
- □ Sarcoidosis
- □ Sjogrens Disease

Integumentary

- □ Rosacea
- □ Albinism
- □ Atopic Dermatitis
- □ Basal Cell Carcinoma
- □ Lupus

Musculoskeletal

- □ Ankylosing Spondylitis
- □ Arthritis
- □ Rheumatoid Arthritis
- □ Down's Syndrome
- □ Marfan's Syndrome
- □ Myasthenia Gravis
- □ Osteoporosis

Neurologic

- □ Bells Palsy
- □ Brain Tumor
- □ Cerebral Palsy
- □ Epilepsy
- □ Multiple Sclerosis
- □ Nystagmus
- □ Seizure Disorder
- □ Vertigo

Psychiatric Disorder

- □ Attention Deficit Disorder
- □ Alzheimer's Disease
- □ Anxiety
- □ Autism
- □ Bipolar Disorder
- □ Dementia
- □ Depression
- □ Learning Disorder

Respiratory

- □ Asthma
- □ Bronchitis
- □ Lung Cancer
- □ COPD
- □ Cystic Fibrosis
- □ Emphysema

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