

Please answer all the questions below to the best of your ability. Our ability to help you is based, in part, upon the accuracy and completeness of your medical/ophthalmic history and description of symptoms.

Name _____ Date _____ Birth date: _____

How would you like us to address you? (First name or Ms./Mrs./Mr./Dr.) _____

Phones: Home _____ Work: _____ Cell: _____

Address _____ Town _____ State _____ Zip _____

Social Security # _____ / _____ / _____ E-mail _____

Occupation: _____ Employer: _____

How did you hear of our office? Insurance plan Family member Yellow pages Other _____

OR by referred by: _____ May we send a thank you note? _____

Please list any members of your family who come to our office: _____

Chief reason(s) for visit: _____

Special visual demands (at work/sports/hobbies): _____

Preliminary Medical History: (see other side of page)

Do you have any allergies to medications? ___No ___ Yes If yes, explain: _____

Please list major injuries and/or surgeries you have had: _____

Who is your primary care physician (internist/family doctor)? _____

Are you pregnant and/or nursing? ___No ___ Yes _____

Family History (of eye disease):

Please note any personal or family history (parents or siblings only; living or deceased) with the following:

Disease / Conditions	No	Yes	Uncertain	Relationship to you / self
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Retinal Detachment/disease	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Insurance Information: (Usually we can just photocopy your card, check at reception before completing)

Primary Vision Care / Major Medical Plan: _____

Policy Holder _____ ID# _____ Group _____

ID# _____ Group # _____

Social History:

Do you drive ___No ___ Yes If yes; have you had visual difficulty when driving? _____No _____ Yes

Do you use tobacco products? ___No ___ Yes If yes, how long? _____

Review of Systems: Do you currently or have you ever had any problems in the following areas:

	No	Yes	Uncertain		No	Yes	Uncertain
Fever, Weight Loss/ Gain	_____	_____	_____	Lupus/other autoimmune	_____	_____	_____
Integumentary (skin)	_____	_____	_____	Allergies / Hay fever	_____	_____	_____
Headaches	_____	_____	_____	Dry throat and/or mouth	_____	_____	_____
Migraines	_____	_____	_____	Asthma	_____	_____	_____
Loss of Vision	_____	_____	_____	COPD / breathing problem	_____	_____	_____
Double vision	_____	_____	_____	High Blood Pressure	_____	_____	_____
Dryness	_____	_____	_____	Other vascular disease	_____	_____	_____
Itching	_____	_____	_____	Rheumatoid Arthritis	_____	_____	_____
Excess tearing	_____	_____	_____	Joint Pain	_____	_____	_____
Infection of eye lid	_____	_____	_____	Anemia	_____	_____	_____
Chalazion/ stye	_____	_____	_____	Bleeding Problems	_____	_____	_____
Flashes/Floaters	_____	_____	_____	Cancer (please note type and status) :	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	Other: _____	_____	_____	_____
Psychiatric:	_____	_____	_____	_____	_____	_____	_____

For 'Yes' answers to any of the above or if you have a condition not listed, please explain. List all drugs you are taking including aspirin, oral contraceptives, hormones, over the counter medications or vitamins:

I have carefully completed this questionnaire to the best of my ability. I understand that my doctor's ability to best care for me (or child) is based significantly on the family/personal health history and description of symptoms.

Patient/Guardian Signature

Date

Doctor's Signature (after reviewing)

Date