Medical History

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Patient Name: _____ Date of Birth: _____

1. Reason for today's visit:
   _____
   _____
   _____
2. Are you in good general health? YES NO
3. Has there been any change in your general health in the last year? YES NO
4. Are you now under the care of a physician? YES NO
   a. If so, what is the condition(s) you are being treated?
      _____
      _____
      _____

Personal Eye History

Have you ever had any of these ophthalmic conditions?

a. Cataract YES NO
b. Cataract Surgery YES NO If yes, which eye, when, and who performed the surgery: _____
c. Any laser surgery YES NO If yes, which eye, when, and who performed the laser: _____
d. Glaucoma YES NO Glaucoma Surgery YES NO
e. Macular Degeneration YES NO If yes, any prior treatment received, when, and who performed the treatment: _____
f. Retinitis Pigmentosa YES NO
g. Retinal Detachment YES NO If yes, which eye, when, and what type of procedure was done to correct the detachment:
   _____
   _____
h. Any eye problems not listed?
   _____
   _____
i. Current eye medication being used, including over the counter medications?

Name	Strength	Frequency	Eye

Past Medical History

1. Other than childbearing, have you been hospitalized or had any surgeries? If yes, please include the operation or reason for hospitalization and the approximate dates.

   _____
   _____
   _____
   _____
   _____

2. Are you taking any medications, including over the counter medications? Please list all medications including strength and dosage. Please attach an additional sheet if needed.

Name	Strength	Dosage

3. Are you allergic to or had reactions to any medications? Please list all medications you are allergic to:

   _____
   _____
   _____

4. Are you allergic to any types of dye? YES NO
5. Are you allergic to iodine or shellfish? YES NO
6. Have you ever had bleeding that required a blood transfusion? YES NO

Family Medical History

Please answer the following questions to the best of your ability and indicate the relationship to the patient. Immediate family includes: Mother, Father, Siblings, Aunts, Uncles, and Grandparents.

1. Has anyone in your immediate family had any of the following ophthalmic conditions?
   a. Cataract YES NO Specify family member(s) _____
   b. Glaucoma YES NO Specify family member(s) _____
   c. Macular Degeneration YES NO Specify family member(s) _____
   d. Retinitis Pigmentosa YES NO Specify family member(s) _____
   e. Retinal Detachmnet YES NO Specify family member(s) _____
2. Has anyone in your immediate family had any of the following medical conditions?
   a. Fainting spells or Seizures YES NO Specify family member(s) _____
   b. Diabetes YES NO Specify family member(s) _____
   c. Hepatitis, jaundice, or liver disease YES NO Specify family member(s) _____

d. Tuberculosis or positive skin test YES NO Specify family member(s) _____
e. Heart disease YES NO Specify family member(s) _____
f. Lung disease YES NO Specify family member(s) _____
g. Arthritis YES NO
h. Kidney disease YES NO
i. Cancer YES NO Specify family member(s) and type of cancer

_____

_____

Personal Social History

1. Do you currently use or have you in the past used tobacco products? YES NO
   a. If yes, please specify the type of tobacco and frequency used.

   _____
2. How frequently do you consume alcohol? Never Rarely Occasionally Daily
3. Have you ever used recreational drugs YES NO
4. What are your living arrangements? Please circle one.

   I am currently: Living in my own home - Living with a family member - In Assisted Living

   A permanent resident of a nursing home - In rehab or a skilled nursing facility

Review of Systems

Do you currently have any of the following diseases or chronic conditions?

Cardiovascular disease	YES	NO	Arthritis or painful swollen joints	YES	NO
High blood pressure	YES	NO	Stomach ulcer or hyperacidity	YES	NO
Stroke	YES	NO	Kidney problems	YES	NO
Allergy	YES	NO	Tuberculosis or positive skin test	YES	NO
Sinus trouble	YES	NO	Persistent cough or cough that produces blood	YES	NO
Asthma or hay fever	YES	NO	Persistent swollen glands in the neck	YES	NO
Fainting spells or seizures	YES	NO	Low blood pressure	YES	NO
Persistent diarrhea or weight loss	YES	NO	Sexually transmitted disease	YES	NO
Hepatitis, jaundice, liver disease	YES	NO	Epilepsy or neurological disease	YES	NO
AIDS or HIV infection	YES	NO	Mental health problems	YES	NO
Thyroid problems	YES	NO	Treatment for tumor/growth	YES	NO
Cancer	YES	NO	If yes, what type _____		
Abnormal bleeding	YES	NO	Blood disorder such as anemia	YES	NO
Respiratory problems	YES	NO	Problems with immune system	YES	NO

Diabetes YES NO If yes, please answer the following questions:

1. How long have you been diabetic? _____
2. Are you using insulin? YES NO If yes, how long and what type: _____
3. Do you check your blood sugar at home? YES NO Average reading: _____
4. Has your doctor told you if you have:
   a. Diabetic kidney damage YES NO DON'T KNOW
   b. Diabetic nerve damage YES NO DON'T KNOW
   c. Diabetic heart damage YES NO DON'T KNOW

Please list any other disease or chronic conditions not listed above that you think we should know about? _____
_____
_____

I certify that I have r ead and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ Date_____