FAMILY EYE PHYSICIANS

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: Date:

Primary reason for today's (first) visit:

Patient Health History

Which of the following pertain to you? Please check "Yes" or "No".

Yes	No		Yes	No	
		Asthma			Head or Spinal Injury
		Kidney Disease			Seizures
		Tuberculosis			Temporal Arthritis
		Diabetes _____ Years?			Carotid Artery Disease
		Insulin			Are You Pregnant
		Migraines			Stroke
		Psychiatric Disorder			HIV
		Nervous Disorder			Extensive Confinement
		Heart Disease			Permanent Defect or Illness
		Ulcer			Sickle Cell Anemia
		High Blood Pressure			Do You Smoke? # Packs per Day

Please list all medications you are currently taking:	Please list all medications you are allergic to:

Patient Ocular History

Yes	No		Yes	No	
		Cataracts			Cornea Disease
		Retina Disease			Glaucoma
		Crossed Eyes			Eye Disorder or Injury
		Iritis			Lens Implant
		Cataract Surgery (Circle) Left or Right			Retinal Surgery (Circle) Left or Right

Patient Surgical History

Please list surgeries, date and type.					

Family History

Has anyone in your family (blood relative) had any of the following?

Yes	No	Relationship to you:	Yes	No	Relationship to you:
		Glaucoma			Retinal Detachment
		Cataracts			Cornea Disease
		Diabetes			Macular Degeneration
		Retinitis Pigmentosa			Diabetic Retinopathy
		Heart Conditions			Stroke
		Other Eye Problems (Describe)			
		Other (Describe)			

Patients Signature: Date:

Physicians Signature: Date: