Associates In Eyecare

MEDICAL HISTORY QUESTIONNAIRE

Name: Birth Date:

Patient Drives: ☐ Yes ☐ No Present Occupation: Today's Date:

Eye History	You	Family	Explain	Notes
Cataracts	☐ No ☐ Yes	☐ No ☐ Yes		
Glaucoma	☐ No ☐ Yes	☐ No ☐ Yes		
Lazy Eye	☐ No ☐ Yes	☐ No ☐ Yes		
Crossed Eye	☐ No ☐ Yes	☐ No ☐ Yes		
Macular Degeneration	☐ No ☐ Yes	☐ No ☐ Yes		
Eye injury/trauma	☐ No ☐ Yes	☐ No ☐ Yes		
Eye Infection	☐ No ☐ Yes	☐ No ☐ Yes		
Blindness	☐ No ☐ Yes	☐ No ☐ Yes		
Other Eye Problems	☐ No ☐ Yes	☐ No ☐ Yes		

REVIEW OF SYSTEMS

	You	Family	Date of Onset	Notes
General/Constitutional (Fever, weight loss, other)	☐ No ☐ Yes	☐ No ☐ Yes		
Ears, Nose, Throat (Sinus, ear infection, cough, dry mouth, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Cardiovascular (Heart, blood pressure, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Respiratory (Asthma, emphysema, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Gastrointestinal (Ulcer, intestinal disease, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Genital, Kidney, Bladder	☐ No ☐ Yes	☐ No ☐ Yes		
Muscles, Bones, Joints (Arthritis, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Skin (Acne, warts, skin CA, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Neurological (Multiple Sclerosis, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Psychiatric (Anxiety, depression, insomnia, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Endocrine (Diabetes, thyroid, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Blood/Lymph (Cholesterol, anemia, etc.)	☐ No ☐ Yes	☐ No ☐ Yes		
Allergic/Immunology	☐ No ☐ Yes	☐ No ☐ Yes		
Other				

MEDICATIONS	MEDICATIONS	List of Eye Medications	Allergies to Meds

Date	Surgeries and Procedures	Surgeon	Co-Management

Date Reviewed	Reviewed By		Date Reviewed	Reviewed By	
	Tech:	Dr:		Tech:	Dr:
	Tech:	Dr:		Tech:	Dr:
	Tech:	Dr:		Tech:	Dr:
	Tech:	Dr:		Tech:	Dr: