

Tidewater Eye Centers, P.C.
Medical History Questionnaire

NAME _____ DATE _____

Date of Birth _____ Age _____ Family Dr. _____ Doctors Phone# _____

What pharmacy do you use? _____ Pharmacy Phone# _____

YOUR PAST MEDICAL HISTORY

Please list all medications you are currently taking, including over the counter and any eye medications. Please include name and dosage. _____

Are you ALLERGIC to any medication(s)? **YES NO Please circle one**

If YES, please list and explain reaction: _____

PLEASE CIRCLE IF YOU HAVE, OR EVER HAD, ANY OF THE FOLLOWING CONDITIONS:

Diabetes / High Blood Pressure / Heart Disease / Thyroid Disease / AIDS / HIV+ / Stroke / Cancer / Lupus / Arthritis / Rheumatoid Arthritis / Hepatitis / Syphilis / Head Trauma or Injuries / Asthma / Emphysema / High Cholesterol

Please list any other illnesses not mentioned above: _____

List any surgical procedures (other than eye surgery) you have had: _____

Do you have a Pacemaker or Automated Internal Cardiac Defibrillator (AICD)? **YES NO Please circle one**

REVIEW OF SYSTEMS (ORGAN SYSTEM)

Do you currently have any problems in the following areas? PLEASE CHECK YES OR NO TO EVERY QUESTION. IF YES, PLEASE PROVIDE EXPLANATION.

	YES	NO	EXPLAIN
General/Constitutional (Fever, Weight Loss, Etc.)	_____	_____	_____
Ears, Nose, Throat (Sinus, Dry Mouth, Etc.)	_____	_____	_____
Cardiovascular (Chest Pain, Shortness of Breath, Etc.)	_____	_____	_____
Respiratory (Wheezing, Coughing, Etc.)	_____	_____	_____
Gastrointestinal (Upset Stomach, Diarrhea, Etc.)	_____	_____	_____
Muscles, Bones, Joints (Aches & Pains, Arthritis, Etc.)	_____	_____	_____
Skin (Rashes, Irritations, Etc.)	_____	_____	_____
Psychiatric (Depression, Anxiety)	_____	_____	_____
Neurologic (Weakness, Headaches, Etc.)	_____	_____	_____
Allergic/Immunologic (Hives, Itching, Etc.)	_____	_____	_____
Endocrine (Diabetes, Hypothyroid, Etc.)	_____	_____	_____
Blood/Lymph (Cholesterolemia, Anemia, Etc.)	_____	_____	_____

(OVER)

PLEASE CHECK YES OR NO FOR EVERY QUESTION BELOW:

Have you ever been diagnosed with any of the following eye problems?

	YES	NO		YES	NO
Cataracts	_____	_____	Tumor of the Eye	_____	_____
Blurred Vision	_____	_____	Herpes of the Eye	_____	_____
Glaucoma	_____	_____	Retinal Problems	_____	_____
Macular Degeneration	_____	_____	Eye Injury	_____	_____
Crossed Eye	_____	_____	Eye Infections	_____	_____
Lazy Eye	_____	_____	Iritis	_____	_____
Other _____					

Please check any vision problems you may be experiencing **WITH YOUR GLASSES ON:**

<input type="checkbox"/> Reading Newspaper	<input type="checkbox"/> Seeing Road Signs
<input type="checkbox"/> Reading Medicine Bottles/Phone Book	<input type="checkbox"/> Driving at Night Due to Glare
<input type="checkbox"/> Seeing to Sew	<input type="checkbox"/> Seeing Halos Around Lights
<input type="checkbox"/> Watching Television	<input type="checkbox"/> Glare from Sunlight
<input type="checkbox"/> Difficulty with Sports, Hobbies, Etc.	<input type="checkbox"/> Difficulty with Home/Work Related Activities

List any other specific vision problems you may be experiencing: _____

YOUR EYE HISTORY

Date of last eye exam: _____ Do you currently wear contact lenses? **YES** **NO**

If Yes, what kind do you wear? _____ How many years? _____

Do you wear prescription eyeglasses? **YES** **NO** If yes, how old are your current glasses? _____

List any eye surgeries or laser treatments you have had, including the date and surgeon's name:

FAMILY HISTORY

Do you have a family history of glaucoma, macular degeneration or other inherited eye disease? **YES** **NO**

If yes please list disease and family members affected: _____

SOCIAL HISTORY

Current Occupation: _____

Do you drink alcohol? **YES** **NO** If Yes: occasional 1 day 2-3 day 4+ day

Do you smoke? **YES** **NO** If Yes: occasional: 1/2 pack day 1 pack day 1+ pack day

Physician's Signature: _____