



PATIENT CHART#:

Patient's
Name

Date of Month Day Year Birth: Medical
Doctor: .

Today's Date

MEDICAL HISTORY- INITIAL QUESTIONNAIRE

List Medications you currently take (Prescription and Over the Counter):
 (Dosages are NOT necessary) _____

Do you have ALLERGIES to any
 Medications? Q YES Q NO If
 YES, list the medications:

REVIEW OF MEDICAL CONDITIONS:

High Blood Pressure ? Q Diabetes: If yes, how many years?
 Heart Condition ? Q Currently PREGNANT?

<i>Please respond if you have other Medical problems:</i>	NO	YES	Explanation of problem
GENERAL/CONSTITUTIONAL: Fever, Weight loss, other?			
EARS, NOSE, THROAT: (Sinusitis, cough, dry mouth, etc.)			
CARDIOVASCULAR: (Heart, vessels, etc.)			
RESPIRATORY: Asthma, emphysema, etc.			
GASTROINTESTINAL: (Ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS: (Arthritis etc.)			
SKIN: (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL: (Multiple sclerosis, stroke, etc.)			
PSYCHIATRIC: (Anxiety, depression, insomnia, etc.)			
ENDOCRINE: (Diabetes, thyroid diseases, etc.)			
BLOOD/LYMPH: Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC: (Hay fever, Lupus, Sjogrens, etc.)			
OTHER CONDITIONS?			

Do you CURRENTLY have any of these OCULAR PROBLEMS? If "YES", provide information:

EYES	NO	YES	Explain
GLAUCOMA Which eye and how treated?			
CATARACT			
Cataract Surgery? (Which eye? When?)			
RETINAL DISEASE			
RETINAL Surgery? (Which eye? When?)			
Any other EYE SURGERY?			
Any LASER Eye Surgery? (Why? When?)			
Blurred vision (at distance or near?)			
Fluctuating vision / Distorted vision (halos)			
Redness / Dryness / Burning / Itching / Discharge?			
Sandy / Gritty feeling / Foreign body sensation			
Excessive tearing / watering			
Glare / Light sensitivity / Pain or Soreness			
Infection of eye or lid (blepharitis, stye)			
Crossed eyes, Wandering eye, Amblyopia			
Double Vision?			
Drooping eyelid (Ptosis)			
OTHER:			

CONTINUED ON BACK

