Medical History/Review of Systems:

List any medications you are now taking including eye drops, birth control pills, vitamins, prescribed medications, or over the counter medications (you may provide a list to us if you have one):

_____

_____

Are you allergic to any medications?

□Yes □No

If yes, please list_____

Primary Care Physician_____ Pediatrician_____

Preferred Pharmacy_____

Do you have or have you ever had any of the following conditions:

Yes	No	Condition
		Asthma/COPD
		Diabetes
		Heart problems
		High Blood Pressure
		Thyroid Problems
		Gastrointestinal Problems
		Urinary problems
		Arthritis
		Musculoskeletal problems
		Endocrine problems
		Neurologic problems (numbness, weakness, stroke)
		Chronic Fever
		Unexpected weight loss/gain
		Seasonal Allergies
		Respiratory problems (shortness of breath, wheezing)
		Ear/nose/throat (hearing loss, sinus)
		Skin problems (rashes, dryness, rosacea)
		Psychiatric problems (depression, anxiety)

Have you ever been exposed to or infected with: □HIV

□Hepatitis Are you currently pregnant or nursing?

Other conditions/illnesses

List any previous major injuries/surgeries/hospitalizations

Do you have or have you ever had any of the following? (check all that apply):

Yes	No	
		Blurred vision
		Double vision
		Loss of vision
		Retinal detachment
		Flashes
		Floaters
		Dry eye
		Glaucoma
		Macular Degeneration
		Cataracts
		Lazy/crossed eye
		Eye injury
		Migraine/headache

Family History (Mother, Father, Grandparents, Siblings):

Yes	No	
		Blindness
		Cataracts
		Glaucoma
		Lazy/Crossed Eye
		Macular Degeneration
		Retinal Detachment
		Diabetes
		Other Eye Disease:

Smoking History:

□ Current Everyday Smoker	□ Former Smoker
□ Current Occasional Smoker	□ Never Smoked

Do you drink alcohol? □Yes □No
Do you use illegal drugs? □Yes □No

If patient is under 18, please complete:
Were there any prenatal, perinatal, or postnatal problems?
Were there any developmental problems?_ _
Do you have any concerns with your child's school performance?

Patient History Questionnaire

Today's Date _____

Title_____ Last Name_____ First Name _____ MI ____

Home Address _____

City _____ State _____ Zip _____

Birthdate (MM/DD/YYYY) _____

SSN# (used for insurance verification only) _____

Contact Information

(Please mark preferred method of contact):

□Cell_____ □Home_____ □Work_____

Email _____ Referred by_____

Employer/School_____Occupation_____

Name of Parent, Legal Guardian, or Spouse_____

Last eye care provider:_____ Date of last eye exam:_____

Are you currently having eye or vision problems? □Yes □No

If yes, please explain_____

Do you wear glasses? □Yes □No How old are they?___ _Are they bifocals? □Yes □No

Are your glasses for □Reading □Distance □Both

Are you interested in correcting your vision with LASIK surgery? □Yes □No

Do you drive?: □Yes □No

If yes, do you have difficulty when driving? □Yes □No If yes, please describe: