Medical History Questionnaire

Date:___/___/___

Name:_____ Date of Birth:___/___/___ Social Security #:_____
Address:_____ City:_____ St:_____ ZIP_____
Home Phone #:_____ Work Phone #:_____ Age:_____ Sex: M F
Medical Doctor's Name:_____ Date of last medical exam: _____
Date of Last Eye Exam:_____ Where was your last exam?_____
How did you hear about Danville Eye Center?

Do you have any allergies to any medications?
YES NO If YES, please list medications below:

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) below:

List all major illnesses (**glaucoma, diabetes, high blood pressure, heart attack, stroke, etc.**) or injuries below:

List any medications you are currently taking (prescription and over-the-counter) below:

FAMILY HISTORY:

Please check YES or NO if anyone in *your immediate family* has had any of the following conditions. If YES, please tell the relationship of the family member to you.

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Cataracts			
Cancer			
Diabetes			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			

GENERAL HEALTH:

Please check YES or NO for the following general health questions about *yourself*. If YES, please explain the condition and write the date the condition began.

General/Constitutional	YES	NO	Date/Description
Fever			
Weight Loss			
Allergic/Immunologic			
Ears, Nose, Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genital, Kidney, Bladder			
Muscles, Bones, Joints			
Skin			
Neurological			
Psychiatric			
Endocrine			
Blood/Lymph			
Other			

SOCIAL HISTORY:

Current Occupation:_____

Women: Are you pregnant or nursing? □YES □NO

Marital Status: □Married □Single □Divorced

Do you currently wear glasses? □YES □NO

If YES, how old are your current glasses?_____

Do you currently wear contact lenses? □YES □NO

If NO, are you interested in contact lenses? □YES □NO

Do you drive? □YES □NO

Do you have problems with night vision? □YES □NO

Do you have visual difficulty when driving? □YES □NO

Are you interested in laser vision correction (i.e. LASIK)? □YES □NO

Do you drink alcohol?
If YES: occasional 1/day 2-3/day 4+/day

Do you smoke?
If YES: occasional ½ pack/day 1 pack/day 1+packs/day

Do you take any drugs that are not prescription or over-the-counter? □YES □NO

Hobbies and Interests:

□Computers □Fishing □Swimming □Hunting
□Racquetball □Basketball □Golfing □Music
Others:_____