Advanced EyeCare

949.777.5970

Medical History Questionnaire

Date:___________

Patient Name:___________ Sex___ Age ___

Referring Physician:___________

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any YES answer.

Current Eye Problem: ____

Eye History:____

Have you ever had eye disease, Surgery, or Injury? Yes☐ No☐

*If **yes**, please describe including dates and the name of the doctor who treated you.*

Date: Doctor: Explain:

Have you ever worn glasses or contact lenses? Yes☐ No☐

How old is your prescription ___________

Have you ever been told that you have Amblyopia or "Lazy eye"? Yes☐ No☐

***Medical History:** Have you ever had surgery or major medical problem? Yes☐ No☐*

*If **Yes** please describe:_____________________________________*

Have you ever had any complication from anesthesia? Yes☐ No☐

*If **Yes** please describe:_______________________________*

***Family History:** If **Yes** to any section below, Please explain relationship to patient*

Blindness	*Yes☐*	*No☐*	___________________________
Cataract	*Yes☐*	*No☐*	___________________________
Glaucoma	*Yes☐*	*No☐*	___________________________
Macular Degeneration	*Yes☐*	*No☐*	___________________________
Strabismus (lazy eye)	*Yes☐*	*No☐*	___________________________
Diabetes	*Yes☐*	*No☐*	___________________________
Heart Attack	*Yes☐*	*No☐*	___________________________
High blood pressure	*Yes☐*	*No☐*	___________________________
Thyroid disease	*Yes☐*	*No☐*	___________________________

Social History:

Does your vision make it difficult for you to do the following task

Read	Yes ☐	No ☐
Write	Yes ☐	No ☐
Drive	Yes ☐	No ☐
Cook	Yes ☐	No ☐
Sew	Yes ☐	No ☐
Watch TV	Yes ☐	No ☐

DO YOU:

Smoke	Yes ☐	No ☐
Drink alcohol	Yes ☐	No ☐
Use recreational drugs	Yes ☐	No ☐

Do you have allergies? Yes ☐ No ☐ if **Yes**, please explain ________________

what kind of reaction have you experienced? ____________________________

____

Medications: you can provide us with the list of your medications if you prefer

Eye Medications: Name:__________ which eye_____ How many times:_____

Other Medications:____

Over the counter medications:___ _________________________________

Review of System**:** Do you have any problem in the following areas? If **Yes** Please explain:

Skin	Yes ☐	No ☐	___________
Head (headaches)	Yes ☐	No ☐	___________
Ears, Nose, Throat, and Mouth	Yes ☐	No ☐	___________
Lung/Breathing	Yes ☐	No ☐	___________
Heart (HTN, heart attack)	Yes ☐	No ☐	___________
Stomach/intestine	Yes ☐	No ☐	___________
Kidney/ Bladder	Yes ☐	No ☐	___________
Bone, Joint, Muscles	Yes ☐	No ☐	___________
Neurologic system	Yes ☐	No ☐	___________
Hematologic/*blood (HIV)*	Yes ☐	No ☐	___________
Allergic	Yes ☐	No ☐	___________
Endocrine(diabetes, thyroid)	Yes ☐	No ☐	___________
Psychiatric	Yes ☐	No ☐	___________
Others	Yes ☐	No ☐	___________