Parkwood Eyecare ASSOCIATES, LLC

MEDICAL HISTORY QUESTIONNAIRE

Date:_____

Name:_____ M.I._____ Birth Date: _____ Age:_____

Address:_____ Social Security#:_____

_____ Home Phone:_____

Email Address:_____ Cell Phone:_____

Occupation:_____ Work Phone:_____

Employer:_____ Marital Status: _____

Medical Doctor:_____ Last Medical Exam:_____

Medical Insurance:_____

Previous Eye Doctor:_____ Last Eye Exam:_____

Vision Insurance: _____ VSP _____ Eye Med _____ Other_____

Responsible Party if different:_____ **Relationship to Patient:**_____

Phone:_____ **Billing Address if different:**_____

Whom may we thank for referring you to our office?: _____

OCULAR HISTORY

Do you wear glasses? YES NO If YES, how old is your present pair of lenses? _____

Do you wear contact lenses? YES NO What type? Soft Toric Multifocal Monovision Gas Permeable

Do you wear them: Full Time Part Time Overnight How often do you replace them?_____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

What other services would you like to be evaluated for? Refractive Surgery Contact Lenses Computer Glasses Reading Glasses Sunglasses Driving Glasses

Are you having any visual difficulties? _____ If yes, please explain:_____

Are you currently experiencing any of the following problems with your vision? **Circle if "YES"**

Blurred Vision	Flashes/Floaters in Vision	Redness
Loss of Vision	Halos/Glare/Light Sensitivity	Excess Tearing/Watering
Loss of Side Vision	Dryness	Eye Pain or Soreness
Distorted Vision	Sandy or Gritty Feeling	Mucous Discharge
Double Vision	Burning	Inflammation of the Eyelid
Tired Eyes	Itching	Styes

Have you been diagnosed with any of the following ocular problems? **Circle if "YES"**

Cataracts	Glaucoma	Retinal Detachment
Crossed Eyes	Lazy Eye / Amblyopia	Dry Eye
Eye Injury	Macular Degeneration	Other_____

OVER

MEDICAL HISTORY

List any medications you are currently taking (include aspirin and over the counter medications):

_____

_____

Do you have any allergies to medications? YES NO if YES, which ones?_____

Do you have any environmental allergies? YES NO if YES, which ones?_____

List all major surgeries and/or hospitalizations you have had:_____

_____

REVIEW OF SYSTEMS

Please circle any problem(s) you currently have, or have had or circle All Normal if none:

ALLERGIC / IMMUNOLOGIC All Normal
- Drug Allergy
- Environmental Allergy
- Lupus

CARDIOVASCULAR / CARDIAC All Normal
- Stroke
- Heart Disease
- High Blood Pressure
- High Cholesterol

CONSTITUTIONAL All Normal
- Fever
- Weight Loss / Gain
- Fatigue

EARS, NOSE, MOUTH, THROAT All Normal
- Sinus Congestion
- Dry Throat / Mouth
- Upper Respiratory infection

ENDOCRINE All Normal
- Diabetes
- Thyroid Disease
- Hormonal Dysfunction

GASTROINTESTINAL All Normal
- Diarrhea / Constipation
- Crohn's Disease
- Ulcers

GENITOURINARY All Normal
- Kidney Disease
- Ovarian / Uterine Cancer
- Prostate Cancer

HEMATOLOGIC / LYMPHATIC All Normal
- Anemia
- Bleeding Problems
- Breast Cancer

INTEGUMENTARY(SKIN) All Normal
- Cancer
- Rashes
- Acne

MUSCULOSKELETAL All Normal
- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

NEUROLOGICAL All Normal
- Migraines
- Dizziness
- Seizures

PSYCHIATRIC All Normal
- Anxiety
- Depression
- Memory Loss

RESPIRATORY All Normal
- Asthma
- Bronchitis
- Emphysema

Please include any conditions you have that are not listed above:_____

_____

Are you currently pregnant and / or nursing? YES NO

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
Glaucoma	_____	Diabetes	_____
Cataract	_____	Cancer	_____
Macular Degeneration	_____	Heart Disease	_____
Retinal Detachment	_____	High Blood Pressure	_____
Blindness	_____	Kidney Disease	_____
Crossed Eyes	_____	Lupus/Arthritis	_____

Signature:_____ Date:_____