Today's Date:

PATIENT MEDICAL, SOCIAL, & FAMILY HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:		Name (if other than patient):
Gender: ☐ M ☐ F	Date of Birth:	Social Security #:

PAST MEDICAL HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No	
Have you had any serious injuries and/or broken bones? ☐ Yes ☐ No	Describe:
Have you ever received a blood transfusion? ☐ Yes ☐ No	Approximate Year(s):
Have you ever traveled or lived outside of the U.S. or Canada? ☐ Yes ☐ No	When & Where:

IMMUNIZATIONS AND DATES:			
☐ Pneumonia	Year:	☐ Influenza	Year:
☐ Hepatitis A	Year:	☐ MMR *Measles, Mumps, Rubella*	Year:
☐ Hepatitis B	Year:	☐ Polio	Year:
☐ Tetanus/Diphtheria within last 10 years	Year:	☐ Shingles	Year:

HAVE YOU HAD ANY OF THE FOLLOWING:		DESCRIBE	FOR MEDICAL TEAM USE ONLY
1. Abnormal chest x-ray	☐ Yes ☐ No		
2. Anesthesia complications	☐ Yes ☐ No		
3. Anxiety, depression, or mental illness	☐ Yes ☐ No		
4. Blood problems (abnormal bleeding, anemia, high or low white count)	☐ Yes ☐ No		
5. Diabetes (Type I or Type II)	☐ Yes ☐ No		
6. Growth removed from the colon or rectum	☐ Yes ☐ No		
7. High blood pressure	☐ Yes ☐ No		
8. High cholesterol or triglycerides	☐ Yes ☐ No		
9. Sexually transmitted disease	☐ Yes ☐ No		
10. Stroke or TIA	☐ Yes ☐ No		
11. Treatment for alcohol and/or drug abuse	☐ Yes ☐ No		
12. Tuberculosis or positive tuberculin skin test	☐ Yes ☐ No		
13. Cosmetic or plastic surgery	☐ Yes ☐ No		
14. Cancer	☐ Yes ☐ No		

Have you ever had a medical problem and/or surgery related to each of the following. If you have had surgery, indicate the approximate year(s) of surgery. Describe the problem and type of surgery. <u>Circle</u> the appropriate choice when multiple choices are listed in a question					FOR MEDICAL TEAM USE ONLY
		SURGERY:	YEAR(S) OF SURGERY:	DESCRIBE:	
1. Ears, nose, sinuses, or tonsils	☐ Yes ☐ No	☐ Yes ☐ No			
2. Thyroid or parathyroid glands	☐ Yes ☐ No	☐ Yes ☐ No			
3. Heart valves or abnormal heart rhythm (afib)	☐ Yes ☐ No	☐ Yes ☐ No			
4. Coronary (heart) arteries (angina)	☐ Yes ☐ No	☐ Yes ☐ No			
5. Arteries (aorta, arteries to head, arms, legs)	☐ Yes ☐ No	☐ Yes ☐ No			
6. Veins or blood clots in the veins	☐ Yes ☐ No	☐ Yes ☐ No			
7. Lungs	☐ Yes ☐ No	☐ Yes ☐ No			
8. Esophagus or gastrointestinal	☐ Yes ☐ No	☐ Yes ☐ No			
9. Bowel (small & large intestine)	☐ Yes ☐ No	☐ Yes ☐ No			
10. Appendix	☐ Yes ☐ No	☐ Yes ☐ No			
11. Liver or gallbladder (including hepatitis)	☐ Yes ☐ No	☐ Yes ☐ No			
12. Hernia	☐ Yes ☐ No	☐ Yes ☐ No			
13. Kidneys or bladder	☐ Yes ☐ No	☐ Yes ☐ No			
14. Bones, joints, or muscles	☐ Yes ☐ No	☐ Yes ☐ No			
15. Back, neck, or spine	☐ Yes ☐ No	☐ Yes ☐ No			
16. Brain	☐ Yes ☐ No	☐ Yes ☐ No			
17. Skin	☐ Yes ☐ No	☐ Yes ☐ No			
18. Breasts	☐ Yes ☐ No	☐ Yes ☐ No			
19. **Females:** uterus, tubes, ovaries	☐ Yes ☐ No	☐ Yes ☐ No			
20. **Males:** prostate, penis, testes, vasectomy	☐ Yes ☐ No	☐ Yes ☐ No			
21. Other (describe)	☐ Yes ☐ No	☐ Yes ☐ No			

1. EYES				
		SURGERY:	SURGERY DATE:	DESCRIBE:
a. Cataract	☐ Yes ☐ No	☐ Yes ☐ No		
b. Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No		
c. Retina/Macula	☐ Yes ☐ No	☐ Yes ☐ No		
d. Lasik	☐ Yes ☐ No	☐ Yes ☐ No		
e. Infection	☐ Yes ☐ No	☐ Yes ☐ No		
f. Eye lid surgery	☐ Yes ☐ No	☐ Yes ☐ No		
g. Dry eyes	☐ Yes ☐ No	☐ Yes ☐ No		
h. Excessive tearing	☐ Yes ☐ No	☐ Yes ☐ No		
i. Eye laser	☐ Yes ☐ No	☐ Yes ☐ No		
j. Glasses	☐ Yes ☐ No	☐ Yes ☐ No		
k. Contacts	☐ Yes ☐ No	☐ Yes ☐ No		

FAMILY EYE HISTORY

	GLAUCOMA	CATARACTS	MACULAR DEGENERATION	INHERITED EYE DISEASE	HYPERTENSION	DIABETES (TYPE I OR TYPE II)
Father						
Mother						
Brother						
Sister						
Son						
Daughter						

REVIEW OF EYE CONDITIONS

		DESCRIBE:
Pain	☐ Yes ☐ No	
Double vision (diplopia)	☐ Yes ☐ No	
Blurred vision	☐ Yes ☐ No	
Dry Eyes	☐ Yes ☐ No	
Excessive Tearing	☐ Yes ☐ No	
Floaters	☐ Yes ☐ No	
Flashes	☐ Yes ☐ No	
Redness	☐ Yes ☐ No	
Itchiness	☐ Yes ☐ No	
Mattering	☐ Yes ☐ No	

MEDICATIONS

Are you currently taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal remedies, and cold medications? ☐ Yes ☐ No

If yes, list medications below:

Name the Drug	Strength	Frequency Taken

ALLERGIES

Have you had hives, skin rash, breathing problems, or other allergic reactions to medications? ☐ Yes ☐ No		Are there medications, other than those you are allergic to, that you would prefer not to take due to prior unpleasant side effects? ☐ Yes ☐ No
Name the Drug	Reaction You Had	Please specify below:

Have you had an allergic reaction to:			
Iodine or X-ray contrast dye	☐ Yes ☐ No	Latex or Rubber	☐ Yes ☐ No
Bee or wasp stings	☐ Yes ☐ No	Adhesive Tape	☐ Yes ☐ No
Metal	☐ Yes ☐ No	Food Allergies? If yes, list:	☐ Yes ☐ No

SYSTEMS REVIEW

Indicate whether you have experienced the following symptoms during recent months, unless otherwise specified, by checking "Yes" or "No" for each question. Circle the symptom(s) you have experienced when multiple symptoms are listed in a question

		For Medical Team Use Only
1. Skin rash, sore, excessive bruising, or change of a mole?	☐ Yes ☐ No	
2. Excessive thirst or urination?	☐ Yes ☐ No	
3. Significant headaches, seizures, slurred speech, or difficulty moving an arm or leg?	☐ Yes ☐ No	
4. Diminished hearing, dizziness, hoarseness, or sinus problems?	☐ Yes ☐ No	
5. Do you wear dentures? If yes: ☐ Full ☐ Upper ☐ Lower ☐ Partial	☐ Yes ☐ No	
6. Bothered with cough, shortness of breath, wheezing or asthma	☐ Yes ☐ No	
7. Coughing up sputum or blood?	☐ Yes ☐ No	
8. Exposed to anyone with tuberculosis?	☐ Yes ☐ No	
9. "Blacked out" or lost consciousness?	☐ Yes ☐ No	
10. Chest pain or pressure, rapid or irregular heartbeats, or known difficulty with a heart valve?	☐ Yes ☐ No	
11. Awakening at night with shortness of breath?	☐ Yes ☐ No	
12. Abnormal swelling in the legs or feet?	☐ Yes ☐ No	
13. Pain in the calves or your legs when you walk?	☐ Yes ☐ No	
14. Gastrointestinal problems i.e. Crohn's, ulcerative colitis	☐ Yes ☐ No	
15. Bladder or urinary problems	☐ Yes ☐ No	
16. Pain, stiffness, or swelling in your back, joints, or muscles?	☐ Yes ☐ No	
17. Fever within the last month?	☐ Yes ☐ No	
18. Enlarged glands (lymph nodes)?	☐ Yes ☐ No	
19. Feel you are at risk for HIV or AIDS?	☐ Yes ☐ No	
20. Immunized for influenza, tetanus/diphtheria and/or pneumonia within the last year?	☐ Yes ☐ No	
21. Weight gain or loss of more than 10 pounds during the last 6 months?	☐ Yes ☐ No	

SOCIAL HISTORY AND SELF-CARE

SOCIAL HISTORY

Occupation	Your current employment status: ☐ Retired ☐ Unemployed ☐ Homemaker ☐ Employed Current Occupation if employed:
Disability	Are you disabled? ☐ Yes ☐ No

Have you used any of the following substances?	**Substance**	**Currently Use?**	**Previously Used?**	**Type/Amount/Frequency**	**How long? (years)**	**If stopped, when? (year)**
	Caffeine: coffee, tea, soda	☐ Yes ☐ No	☐ Yes ☐ No			
	Tobacco	☐ Yes ☐ No	☐ Yes ☐ No			
	Alcohol: beer, wine, liquor	☐ Yes ☐ No	☐ Yes ☐ No			
	Recreational/street drugs	☐ Yes ☐ No	☐ Yes ☐ No			

SELF-CARE/HOME ENVIRONMENT ASSESSMENT

Do you have difficulty performing these activities by YOURSELF due to vision?			
	Eating	☐ Yes ☐ No	
	Bathing	☐ Yes ☐ No	
	Dressing	☐ Yes ☐ No	
	Walking	☐ Yes ☐ No	
	Using Toilet	☐ Yes ☐ No	
	Housekeeping	☐ Yes ☐ No	