July 1 2013 New

Pleasant View Eye Wear & Eye Care
Medical History Questionnaire

Name: ______________________ Birthday: ______________________ Date: _______

Last Eye Exam? ______________ Last Blood Pressure Check? _________

Last Medical Exam? ______________ Primary Care Doctor ____________

Height _____ Weight _____

All information will be held in confidence and reviewed by the doctor.

Do you have any medical problems in the following areas? If Yes Please discuss with the doctor.

Please circle or print sign/symptom under other

ROS		OTHER Please LIST	Check Mark YES	NO
Eyes	Blurred vision, irritation, pain, tearing, redness, etc.?			
General	Fever, heat stroke, weight loss, weight gain, very tired?			
ENT	Ear ache, cough,hearing, sore throat etc			
Cardiovascular	High blood pressure, heart disease, racing pulse, etc.?			
Respiratory	Asthma,congestion, wheezing, short of breath, etc.?			
GI	Stomach upset, diarrhea, constipation, ulcers, etc.?			
Neph/Gyn/Urinary	Painful or frequent urination, etc.?			
Female	Are you pregnant? Or nursing?			
Bone/muscle	Joint pain, stiffness, swelling, Arthritis, etc.?			
Skin	Skin Cancers, rosacea other facial derm disorder?			
Neuro	Numbness, headaches, seizures paralysis, etc.?			
Psych	Anxiety, depression, insomnia, etc.?			
Endocrine	Diabetes, hyper or hypothyroid, etc.?			
Blood/Lymph	High cholesterol or blood lipids, anemia, etc.?			
Allergy	Sneezing, itching, swelling,hives			

SURGERY

Eye History **Please Circle YES or NO**

			When
Have you ever sustained an injury to the eyes?	YES	NO	
Have you ever had eye surgery?	YES	NO	
Do you have any NEW flashers or floaters?	YES	NO	
Have you ever had complications wearing contact lenses?	YES	NO	
Have you had any recent eye infections?	YES	NO	

	Yourself	Parent	Sibling
Macular Degeneration (AMD)			
Cataract			
Glaucoma			
Diabetes			
High Blood Presure			
Heart Disease			
Stroke			
Cancer			
Thyroid Disease			
Arthritis			
Other Heritable Disease : ______________			

Please use abbreviations:

Brother	B
Siister	S
Grandparent	G
Mother	M
Father	F
Yourself	Y

DR RV HX date	SIGN

Social History **Please circle YES or NO**

Does your vision limit any activities of daily living (driving, reading, work, etc.)? YES NO

IF over age 50 have you had a Zostavax Vaccination? YES NO

Have you had a blood transfusion before 1987? YES NO

Do you drink alcohol beverages? YES NO If yes 1-2/week ___ 5-6/week___ more_______________

Do You smoke? Everyday___ occasional __ never__ former ____

Do you use "street" drugs? Yes NO Do you use "medical" Marijuanna' YES NO

Are you allergic to any drugs or latex? If so please list:

Are you currently taking medicatations? If so please supply list with frequency and dosages:

Signature (patient) ______________________________ Date __________