



Physician's Eye Care & Laser Center

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HEALTH HISTORY AND QUESTIONNAIRE

Name _____ Date _____

Chief complaint _____

Date of last exam (if known) _____ Do you drive? _____

- | | | |
|-----------------------|-----------------------|------------------------------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Asthma |
| <input type="radio"/> | <input type="radio"/> | Tuberculosis |
| <input type="radio"/> | <input type="radio"/> | Diabetes IDDM/Type II _____ # yrs. |
| <input type="radio"/> | <input type="radio"/> | Psychiatric Disorder |
| <input type="radio"/> | <input type="radio"/> | Migraines |
| <input type="radio"/> | <input type="radio"/> | Heart Disease |
| <input type="radio"/> | <input type="radio"/> | Ulcer |
| <input type="radio"/> | <input type="radio"/> | High Blood Pressure _____ # yrs. |
| <input type="radio"/> | <input type="radio"/> | Sickle Cell Anemia |
| <input type="radio"/> | <input type="radio"/> | Seizure, Convulsions, Fainting |
| <input type="radio"/> | <input type="radio"/> | Temporal Arteritis |
| <input type="radio"/> | <input type="radio"/> | Carotid Artery—Disease |
| <input type="radio"/> | <input type="radio"/> | Stroke |
| <input type="radio"/> | <input type="radio"/> | HIV |
| <input type="radio"/> | <input type="radio"/> | Thyroid Disease |
| <input type="radio"/> | <input type="radio"/> | Cholesterol |
| <input type="radio"/> | <input type="radio"/> | Kidney Disease |

FAMILY DOCTOR _____

DOCTORS PHONE NUMBER _____

Do you smoke? Yes No

Do you drink? Yes No

Do you live alone? Yes No

OCCUPATION: _____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS? Yes No

(If yes, list all medications you're allergic to.)

OCULAR HISTORY (Have you been diagnosed with any of the following in the past)

- | | | |
|-----------------------|-----------------------|-----------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Cataracts |
| <input type="radio"/> | <input type="radio"/> | Retinal Disease |
| <input type="radio"/> | <input type="radio"/> | Iritis |
| <input type="radio"/> | <input type="radio"/> | Other _____ |

- | | | |
|-----------------------|-----------------------|-----------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Corneal Disease |
| <input type="radio"/> | <input type="radio"/> | Glaucoma |
| <input type="radio"/> | <input type="radio"/> | Injury |

Cataract Surgery (Date of Surgery) _____ Right _____ Left _____

Do you have a Lens Implant? Yes No

Retinal Surgery? Right _____ Left _____

FAMILY HISTORY (Have any of your blood relatives had any of the following? If so please specify.)

- | | | |
|-----------------------|-----------------------|----------------------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Glaucoma _____ |
| <input type="radio"/> | <input type="radio"/> | Cataracts _____ |
| <input type="radio"/> | <input type="radio"/> | Corneal Disease _____ |
| <input type="radio"/> | <input type="radio"/> | Macular Degeneration _____ |
| <input type="radio"/> | <input type="radio"/> | Retinitis Pigmentosa _____ |
| <input type="radio"/> | <input type="radio"/> | Other Eye Problems _____ |

- | | | |
|-----------------------|-----------------------|-----------------------------|
| Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Diabetes _____ |
| <input type="radio"/> | <input type="radio"/> | Heart Conditions _____ |
| <input type="radio"/> | <input type="radio"/> | Diabetic Retinopathy _____ |
| <input type="radio"/> | <input type="radio"/> | Retinal Detachment _____ |
| <input type="radio"/> | <input type="radio"/> | Stroke _____ |
| <input type="radio"/> | <input type="radio"/> | Other Health Problems _____ |

SURGICAL HISTORY (Please indicate date and type)

TECHNICIAN SIGNATURE

DOCTORS SIGNATURE