



Date: _____

Name: _____ Date of Birth: _____

To help us serve your eye care needs it is important that we have accurate information regarding your general medical health. Please complete the form below and return in the enclosed envelope prior to your appointment. Thank you.

Medical Doctor: _____ Phone Number: _____

General Health History: (If you need more space you can write on the back of this page.)

Do you have any of the following?	No	Yes	If yes, please explain.
Heart/Blood Pressure issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Throat issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung/Breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reproductive/Urinary Tract issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle/Skeletal issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain/Neurological issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy/Immunity issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/Diabetes/Thyroid issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

Prescription and Over-the-Counter Medications: Name and Dosage (Dosage is very important):

Medication Allergies: _____

Any surgeries you have had: _____

Do you have any special needs? Wheelchair Walker Hearing Aids
Interpreter (Language) _____ Other: _____

(Please see back side of this form for pediatric patients)

MEDICAL HISTORY QUESTIONNAIRE
(For Pediatric Patients Only)

Name: _____ Birth Date: _____ Sex: M F Race: _____

Allergies to Medications: _____

Prior hospitalizations and surgeries: _____

Current medications (dose and reason for taking): _____

Birth weight: _____ Premature or full term: _____

Prenatal problems: _____

Birth or neonatal problems: _____

Pediatrician or family doctor: _____ Last physical exam: _____

Are immunizations up to date? _____

SYSTEM REVIEW:

Does your child have, or, has your child had any of the following?

Diabetes mellitus: _____ Cancer or leukemia: _____

Juvenile rheumatoid arthritis: _____ Bleeding disorder: _____

Hepatitis: _____ HIV virus: _____

Chromosome abnormality: _____

Syndrome or identified genetic disease: _____

Other disease: _____

Serious injury: _____

Skin problems or abnormalities: _____

Neurologic problems: _____

Cerebral palsy: _____ Seizure disorder: _____ Developmental delay: _____

Learning disability: _____ ADD/ADHD: _____ Hydrocephalus: _____

Other: _____

Heart murmur: _____ Cardiac abnormality: _____

Asthma: _____ Other lung problems: _____

Hearing problems: _____

Bone, joint or limb abnormalities: _____

Kidney or urinary tract problems: _____

Bleeding disorder: _____

Has your child had an abnormal reaction to eye medication? _____

Any previous eye care? _____

FAMILY HISTORY:

Is your child adopted or a foster child? _____

Please list patient's relation to any biologic family members who have had the following:

Eye muscle problem: _____

Amblyopia or "lazy eye": _____

Glasses as a young child or infant: _____

Cataracts (diagnosed under age 40): _____

Glaucoma: _____

Poor eyesight not corrected with glasses or contacts: _____

Tear duct problems: _____

Poor color vision: _____

Other: _____

Date: _____ Signed: _____ Relation to patient: _____