OPHTHALMOLOGY LTD.

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	☐	☐	_____
Ear/Nose/Throat issues	☐	☐	_____
Lung/Breathing issues	☐	☐	_____
Stomach/Bowel issues	☐	☐	_____
Reproductive/Urinary Tract issues	☐	☐	_____
Skin issues	☐	☐	_____
Muscle/Skeletal issues	☐	☐	_____
Brain/Neurological issues	☐	☐	_____
Blood issues	☐	☐	_____
Allergy/Immunity issues	☐	☐	_____
Cancer/Diabetes/Thyroid issues	☐	☐	_____
Other:	☐	☐	_____

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: _____