

EYE CARE ASSOCIATES OF SEVIER COUNTY MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____

Family Physician(s): _____ Approximate date of last eye exam _____

Medicines currently taking: _____

Allergies to Medicine: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If so provide information.

	YES	NO	EXPLANATION OF PROBLEM
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head, Brain, Nerves	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat, Neck, Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs, Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart or Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach, Intestines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney, Bladder, Prostate	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones, Muscles, Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

Past or current eye problems and eye surgeries: _____

Past surgical or medical problems not listed above: _____

Have you ever worn contact lenses? **Y / N** Do you wear contact lenses now? **Y / N**

If not why did you quit? _____

Are you interested in wearing contact lenses now? **Y / N** Are you required to wear safety glasses? **Y / N**

Would you be interested in a lens that is scratch and shatter resistant, featherweight, and that protects your eyes from the sun's harmful rays? **Y / N** Would you be interested in lenses that are sunglasses outdoors and clear in doors? **Y / N**

Would you be interested in a coating on your glasses that would reduce or eliminate glare? **Y / N**

Do you work on a computer more than an hour a day? **Y / N**

What are some of your hobbies? _____

Would you be interested in laser vision correction? **Y / N**

Family History: Macular Degeneration **Y / N** Glaucoma **Y / N** Blindness **Y / N**

Other _____

Do You Smoke? **Y / N** Drink Alcohol? **Y / N** Use Street Drugs? **Y / N**

Do you have HIV or AIDS? **Y / N**

Doctor's Signature	Date	Patient Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____