Norfolk Eye Physicians and Surgeons Dr. CGC____ Dr. RWS____ Dr. AYK_____ Tech init.________

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Last Name: ________________________ First Name: __________________ DOB: ______________ Date:______________

MEDICAL HISTORY QUESTIONNARE

Updated 1/10/12)

Medical Dr's. Name: ______________________________________ Phone Number: ________________________________
Clinic Name: ____ Fax Number: __________________________________
Last visit: __________________ Next visit: ____________________ Misc. ____

List all medications you are taking **with dose and times per day** (including **over-the counter** and **non-Rx supplements**) and the reason you take them

Medications (including for eyes)	Taken for:	List any ALLERGIES to Medication
		List any major illnesses / injuries
		Date:
		Date:
		Date:
		List any surgeries (including for eyes)
		Date:
		Date:
		Date:

Indicate whether you have ever had any of the following: Place an "X" in the box.

Symptoms	Past	Now			Briefly Explain	Symptoms	Past	Now			Briefly Explain
Loss of vision						Feels like something is in your eye					
Blurred vision						Scratchy or gritty feeling					
Vision that changes (clear, unclear)						Dryness					
Distorted vision (ie, halos)						Burning or stinging feeling					
Glare or light sensitivity						Redness					
Night vision problems						Itching					
Double vision						Crossed Eye or "Lazy Eye"					
Flashes of light						Color Vision Problems					
Floating spots or lines						Cataracts					
Eye pain, soreness, tired eyes						High eye pressure					
Infections of eye or eyelid						Glaucoma					
"Styes"						Macular Degeneration					
Crusty or sticky eyelids						Corneal or other retinal disease					
Mucous discharge						Laser Vision Correction					
Unusual tearing or watering						Other:					

Dr.'s Notes:

Have your eyes been DILATED before? yes/no When: ____________

If dilated before, any adverse reaction other than temporary blurred vision and light-sensitivity? Explain:

Are you PREGNANT or NURSING? Yes/No

BREAST FEEDING? Yes/No

Did you drive today? yes/no

Patient Last Name: ______________________________ First Name: ____________________ DOB: ________________

Indicate whether you have or ever had problems in the following areas. Place an "X" in the box and **CIRCLE** item(s).

Systemic & Other	Past	Now	Briefly Explain
GENERAL/CONSTITUTIONAL (fever, weight loss/gain)			
INTEGUMENTARY (skin)			
NEUROLOGICAL (headaches, migraines, seizures)			
EARS, NOSE, THROAT (ear ache, stuffy nose, sinus congestion, dry throat/mouth, allergies/hay fever)			
RESPIRATORY (asthma, bronchitis, emphysema)			
GASTROINTESTINAL (stomach, diarrhea, constipation)			
GENITOURINARY (genitals, kidney, bladder)			
BONES/JOINTS/MUSCLES (rheumatoid arthritis, joint pain, muscle pain, stiffness, cramps)			
BLOOD/LYMPH (anemia, high cholesterol, bleeding)			
ENDOCRINE (thyroid)			
VASCULAR/CARDIOVASCULAR (diabetes, high blood pressure, heart, stroke, etc.)			
ALLERGIC/IMMUNOLOGIC (lupus, cancer)			
PSYCHIATRIC (anxiety, depression, bipolar, etc.)			
(Have or exposed to)Tuberculosis, Hepatitis, HIV			
Cancer			
Fibromyalgia Syndrome			
ADD, ADHD, etc.			

If you are a DIABETIC patient, please provide the additional information:

Type (circle): Juvenile, Type II, Gestational When diagnosed? ______________ Any vision complications? yes/no

Do you monitor your own blood glucose levels? yes/no (loss of vision, fluctuating vision)

What is the average range of your readings? between _______ and _______Last Blood Glucose ________ Date__________

Was your last HbA1C (tests levels over a few months range) normal? yes/no/don't know ____________ Date__________

Last visit to your medical Dr. __________________ Next visit ___________________ Frequency of visits _______________

FAMILY and Other Patient Information

Indicate whether any of these conditions exist with your family (blood-relatives) and indicate WHO

M = mother, F = father, S = sister, B = brother, Gma = grandma, Gpa = grandpa, A = aunt, U = uncle

(ie, MGma = maternal grandma, PGma = paternal grandma, MA = maternal aunt, etc.)

Family Ocular History	Who	Family Systemic History	Who	Dr.'s notes
Blindness		Stroke		
Glaucoma		Heart Disease		
Macular Degeneration		High Blood Pressure		
Retinal Disease or Detachment		Diabetes		
Crossed Eyes		Cancer		
Color Vision Problems		Other Health Problems		
Other Eye Problems				

Corrective Lenses information:

1) Do you wear glasses? yes/no
   Type (circle): single vision, bifocals, trifocals, or no-line progressives?
2) Do you like your type of glasses? yes/no
   If no, why not? ____
3) Do you wear sunglasses? yes/no Are they Rx? yes/no
4) Do you use the computer? yes/no
   If so, about how many hours a day? _______________________hours

Contact Lens information:

1) Do you (or did you) wear contact lenses? yes/no…ran out
   If yes, (circle) soft lenses or hard (rigid) lenses?
2) If no, are you interested in wearing contact lenses? yes/no

Social Information:

1) Do you drink? yes/no/quit
2) Do you smoke? yes/no/quit
3) Do you use drugs? yes/no/quit
4) Do you live alone? yes/no

Driving Information:

1) Do you drive? yes/no If yes,
   a) Do you have difficulty driving at night/in the dark? yes/no
   b) Do you have any driving restrictions? yes/no (ie, no freeways, daytime only)
   ____