ALL SAINTS EYE CENTER
Medical History Questionnaire **Name:** ____
Date of Birth____________________**Chart #**___________________

Please check each item Yes or No as they relate to your health:

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____Yes _____No If yes, please list_____________

Hematologic/Lymphatic	**Yes**	**No**	**Respiratory**	**Yes**	**No**	**Cardiovascular**	**Yes**	**No**
Anemia			Cough			Heart Disease		
Bleeding/Bruising			Wheezing			Heart Attack date		
			Emphysema			Angina		
Ear/Nose/Throat			Asthma			Stroke, date		
Hearing Loss			**Endocrine**			High Blood Pressure		
Hearing Aids			Diabetes, years________			**Genitourinary Problems**		
Gastrointestinal			Thyroid			Kidney		
Ulcers			**Musculoskeletal**			Bladder		
Colitis/Diverticulitis			Arthritis			Prostate		
Liver/Hepatitis			Joint Replacement			**Cancer**		
Skin Problems			**Constitution**			Location		
Keloids/Scarring			Weight Loss			Radiation		
EYES			Fatigue			Chemotherapy		
Double Vision			**Psychiatric**			**Neurologic**		
Pain			Anxiety			Seizures		
Floaters or Spots			Depression			Convulsions		
Flashes of Light			Mood Swings			Alzheimer’s		
Dry Eyes						Parkinson’s Disease		
Decreased Vision						**Other**		
Sandy/Gritty Feeling								
Excessive Tearing								

Past Medical History: (please list any surgery, injuries, operations or hospitalizations other than eyes)

Please list all MEDICATIONS that you are currently taking INCLUDING EYEDROPS & VITAMINS

Medication	**Strength**	**How Often**	**Medication**	**Strength**	**How Often**

EYE HISTORY: please circle the items, which you have been diagnosed with:

Cataracts	Y	N	Macular Degeneration	Y	N
Diabetic Retinopathy	Y	N	Retinal Disorders	Y	N
Glaucoma	Y	N	Retinal Detachment	Y	N

Eye Surgery/Eye Trauma Please List:

Right Eye____

Left Eye____

Family/Social History: Check Yes or No as related to your Family History. Explain positive responses, ie: Mother, Father, Sister, etc.

	Yes	No	Family Member		Yes	No	Family Member
Glaucoma				Diabetes			
Cataract				Hypertension			
Retina: example: macular degeneration, detachment…				Vascular			
Cardiac				Cancer			

Reviewed by Tech_________________ **_Dr.**______________________

Patient Signature_________________________________**Date**______________

Jeffrey L.Zimm,M.D./Len A.Brown O.D, Eric Donaghy, O.D.
Daniel Hachey, O.D./ Andrew J. Hart, O.D.

Over for Updates ☐ **Immokalee Road** ☐**Davis Blvd.** ☐**Fort Myers** ☐ **Gladiolus Drive**

Med History 102

UP DATES

Reviewed by___________________/______________Date_________________(   ) Updated   (   ) No Change

Reviewed by___________________/______________Date_________________(   ) Updated   (   ) No Change

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