ALL SAINTS EYE CENTER

Medical History Questionnaire Name:_____

Date of Birth: _____Chart#:_____

Please check each itme 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			**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, injuires, operations or hospitalizations other than eyes)

_____

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

Medication	Strength/Frequency	Medication	Strength/Frequency

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

Cataracts	YES	NO	Macular Degeneration	YES	NO
Diabetic Retinopathy	YES	NO	Retinal Disorders	YES	NO
Glaucoma	YES	NO	Retinal Detachment	YES	NO

Eye Surgery/Eye Trauma Please List

Right Eye: _____

Left Eye: _____

Family/Social History: Check Yes or No as related to your family history and which family member			
	YES/NO/FAMILY		YES/NO/FAMILY
Glaucoma		Diabetes	
Cataract		Hypertension	
Retina		Vascular	
Cardiac		Cancer	

PATIENT SIGNATURE:_____ REVIEWED: _____ DATE:_____