

Medical History Questionnaire - Envision Eye Specialists
 (Please print clearly and use the back of this page if you need more space)

Today's Date _____

Name _____

Your Age _____ Your Birthplace _____

Who is your medical doctor? _____

Medical Dr. Location/Phone _____

What is the main reason for your visit today?

Do you have any of these symptoms?

- Blurred distance vision Glare, halos around lights
- Blurred reading vision Itching or burning eyes
- Constant double vision Eye mattering or tearing
- Flashing lights or floaters Foreign body sensation
- Red Eyes Dry Eye Eye Pain

Do you have any allergies to any medications?

- None known Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____

Which eye medications do you currently take?

- None Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which other medications do you currently take?

- None Aspirin on a daily basis

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

- Cataract Serious eye injury
- Glaucoma Iritis/uveitis
- Macular degeneration Lazy eye
- Wore eye patch as a child Retinal detachment
- Other: _____

Have you ever had any of these conditions?

- None
- Stroke Dizziness High blood pressure
- Arthritis Allergies Heart disease
- Diabetes AIDS, HIV Lung diseases
- Cancer Anemia Thyroid disease
- Headaches Other: _____

Have members of your family had any eye diseases?

(this would be your father, mother, sister, brother, grandparents)

- Glaucoma Diabetic eye disease or diabetes
- Cataract Crossed eyes Macular degeneration
- Iritis/uveitis Blindness Retinal Detachment
- Poor vision Other _____

Please list any eye surgeries you have had:

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any other surgeries you have had:

- None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illness have caused a hospital stay?

If you have glaucoma:

In what year was the diagnosis first made? _____

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you use? Tobacco Alcohol

Would you like to wear contact lenses?

- Yes Not interested at this time

What was the approximate date of your last eye examination: _____

OVER PLEASE

REVIEW OF SYSTEMS

Today's Date: _____

For new patients, established patients who may be having a new problem, or our patients who we haven't seen in a while, we need to update our records as to your general medical health. In each area if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this please ask one of the technicians, or your doctor.

Const. (Health in General) No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.

Other: _____

Ears, Nose, Mouth & Throat No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.

Other: _____

C-V (Heart & Blood Vessels) No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet.

Other: _____

Resp. (Lungs & Breathing) No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.

Other: _____

GI (Stomach & Intestines) No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.

Other: _____

GU (Kidney & Bladder) No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.

Other: _____

MS (Muscles, Bones, Joints) No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.

Other: _____

Integ. (Skin, Hair & Breast) No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.

Other: _____

Neurological (Brain & Nerves) No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.

Other: _____

Psychiatric (Mood & Thinking) No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.

Other: _____

Endocrinologic (Glands) No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.

Other: _____

Hematologic (Blood/Lymph) No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.

Other: _____

Allergic/Immunologic No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____