

Alabama Ophthalmology Associates, P.C.
Medical History Questionnaire - Adult

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Referring Physician: _____ Address: _____

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer.

Current Eye Problem: _____

Ocular History

Have you ever had any eye disease, surgery or injury? No Yes

If yes, please describe including dates and the name of the doctor who treated you.

Date	Doctor	Description

Have you ever worn glasses or contact lenses? No Yes

How old is your prescription? _____

Have you ever been told you have amblyopia or "lazy eye"? No Yes

Medical History

Have you ever had major surgery or been hospitalized for any reason? No Yes

If yes, please describe: _____

Have you ever had any complications from anesthesia? No Yes

If yes, please describe: _____

Do you have a pacemaker or defibrillator? No Yes

If yes, please provide the manufacturer's card. _____

Are you a hospice patient? No Yes

If yes, please give the name and number of program. _____

Family History:

Blindness	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cataract	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Heart Attacks	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Glaucoma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	High Blood Pressure	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Macular Degeneration	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Strabismus (Lazy Eye)	No <input type="checkbox"/>	Yes <input type="checkbox"/>			

If yes to any of the above, please explain relationship to patient: _____

Social History:

Does your vision make it difficult for you to?

- Read? No Yes
- Write? No Yes
- Drive? No Yes
- Cook? No Yes
- Sew? No Yes
- Watch TV? No Yes
- Work? No Yes

Do you:

- Smoke? No Yes
- Chew tobacco? No Yes
- Drink alcohol? No Yes
- Use drugs? No Yes

Do you have any allergies?

- No Yes

If yes, please describe: _____

What kind of reactions have you experienced? _____

Medications

Please list any medication(s) including eye drops, which you are currently taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Which Eye?

Review of Systems

Do you have any problem in the following areas? If yes, please explain.

- Skin No Yes _____
- Head (Headaches) No Yes _____
- Ears, Nose, Throat and Mouth No Yes _____
- Lungs/Breathing (TB) No Yes _____
- Heart (High Blood Pressure) No Yes _____
- Stomach/Intestines No Yes _____
- Genitals, Kidney, Bladder No Yes _____
- Bones, Joints, Muscles No Yes _____
- Neurologic System No Yes _____
- Lymph Nodes/Swelling No Yes _____
- Blood (HIV Positive, Hepatitis) No Yes _____
- Allergic, Immunologic No Yes _____
- Endocrine (Diabetes, Thyroid) No Yes _____
- Psychiatric No Yes _____
- Other No Yes _____