EYE PHYSICIANS AND SURGEONS OF COLUMBIA, P.A.

MEDICAL HISTORY QUESTIONNAIRE

Name ____________________________Date _______ Date of birth_______________Age___

Pharmacy Address & Phone____

Primary Care Physician _________________________**Referred by**_____________________

List any **MEDICATIONS** you currently take:
(prescription and over-the-counter): ____

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List any **EYE DROPS** you currently use____

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List any **ALLERGIES** to any medications: ____

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List all **MAJOR ILLNESSES** (diabetes, high blood pressure, etc.) or **INJURIES** (concussion)

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List any **SURGERIES** you have had (tonsillectomy, appendectomy) and year:______________

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REVIEW OF SYSTEMS

Do **you** ***CURRENTLY*** have any problems in the following areas?	**NO**	**YES**	**Explanation of Problem**
EYES (Glaucoma, cataract, retinal disease)			
GENERAL (Fever, weight loss, etc.)			
HIGH BLOOD PRESSURE			
DIABETES			
THYROID			
CANCER			
CARDIOVASCULAR (Heart, vessels)			
EARS, NOSE, THROAT (Sinus, ears, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (ulcers, intestines, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
BLOOD/LYMPH (high cholesterol, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

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FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PT
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY Current Occupation:______________________________________

Education (high school, vocational school, college degree): __________________________

Marital Status (married, divorced, single, widowed): ______________________________

Do you drive? YES NO At night? YES NO

Do you drink alcohol? YES NO Do you smoke? YES NO

EYE HISTORY

	NO	YES	DESCRIBE
Have you ever had an **eye injury** or **eye surgery** ? What type?			
Have you been told that you have a "lazy eye" or **amblyopi**a?			
Were your eyes "**crossed**" as a child? Did you wear a **patch**?			
Do you have any **eye diseases**?			
Have you ever been told that your eye **pressure** is high?			
Do you have a **family history** of : **Glaucoma**?			
Cataracts?			
Retinal detachment?			
Severe vision loss or blindness?			
Macular Degeneration?			
Corneal Transplant?			
Are you a past or present **glasses** wearer?			
Are you a past or present **contact lens** wearer?			
Have you ever had a **corneal ulcer**?			
Do you have any **eye conditions not mentioned**?			

Current Contact Lenses: What solutions do you use? ________________________

Right ______________ Brand ________________ **How long** do you wear 1 pair? ______________

Left _______________ Base Curve____________ Do you **sleep** in your contacts? _______________

History reviewed. _______ No Changes. ______ Additions as noted above

Physician's Signature: ________________________________