VALLEY EYE ASSOCIATES
MEDICAL HISTORY QUESTIONNAIRE

(PLEASE PRINT) (11-3-11)

Name: Birth Date: Date:

Email Address:______________________________

Race (please circle): Caucasian African-American Asian Hispanic Pacific-Islander Multi-racial Other__________

Name and city of your General Physician:______________________City:______________

Current **EYE medications and dosage** (prescribed or over-the-counter):________ ________ ________

Current **medications and dosage**: (include prescription meds, insulin, over-the-counter and vitamins):

Any allergies to medications? **YES** **NO** If yes, list which ones:______________________

List any **EYE** related diseases, injuries or surgeries:______________________

List all major surgeries, conditions or illnesses (diabetes, high blood pressure, heart attack, (concussion, etc):

Do you **CURRENTLY** have any problems in the following areas? If YES, please provide additional information.

	Yes	No	Details
Ocular – red, itchy, watery, blurry, pain, mattering?			
Cardiovascular -heart problems or hypertension?			
Respiratory -shortness of breath?			
Constitutional -fatigue, weight gain or loss, etc.?			
Gastrointestinal - acid reflux, nausea, bowel problems?			
Genitourinary - urinary tract infections, kidney stones?			
Musculoskeletal - broken bones, tendonitis, bursitis?			

Immunological/Allergies – rheumatoid arthritis, lupus, allergies?			
Ear, Nose, Throat - sinusitis, sore throat?			
Neurological- headaches?			
Psychological - depression, anxiety?			
Dermatological – rashes, skin problems?			
Endocrine – diabetes, thyroid disease			
Females – are you pregnant? nursing?			

FAMILY HISTORY (Parents, Sibling, Grandparent)

Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**
Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Heart Disease, Cancer

If yes, please explain relationship:________ _______ ________ _________________ _______ ____________ __________

SOCIAL HISTORY

Do you smoke?……………. **YES NO** If **YES**, how much? ___________ per day How many yrs?_______