Medical History Questionnaire

Atlantic Vision Center
3910 Shipyard Blvd, Wilmington, NC 28403
(910) 799-0220

Name: ______________________________ **Today's Date:** ____________

Date of Birth: ____________ **Last Eye Exam:** ____________ **Occupation:** ____________

Please fill out this form in it's entirety. If a section does not apply to you, please write "none".

Medications: *(ONLY list Rx and non-Rx medications here; list all VITAMINS below. **If you have a list, we can copy it.**)*

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

Vitamins: ______________________________

Do you have any allergies to medications? **Yes** ☐ **No** ☐

If Yes, please list the medications and in parenthesis list what type of reaction is experienced.

____

EYE Surgeries (with dates)**:** ______________________________

EYE Diseases (i.e. glaucoma, AMD, etc**)**______________________________**If none** check here: ☐

OTHER Surgeries:______________________________

Do you currently have any problems with the following areas? *If Yes, please explain.*

Eyes	Yes	No	Explanation:
Ocular Disease (glaucoma, cataracts, retinal disease, etc)	☐	☐	____________
Loss of vision, blurred vision, or fluctuating vision	☐	☐	____________
Double vision	☐	☐	____________
Floaters and/or Flashes (please explain)	☐	☐	____________
Redness	☐	☐	____________
Mucous discharge or drainage	☐	☐	____________
Foreign body sensation, sandy or gritty feeling	☐	☐	____________
Itching, burning, watering (excessive tearing)	☐	☐	____________
Dryness	☐	☐	____________
Eye pain/soreness	☐	☐	____________
Glare/light sensitivity	☐	☐	____________
Crossed eyes or "lazy eye" (amblyopia)	☐	☐	____________
Drooping eyelid	☐	☐	____________
Eyelid issues (stye, chalazion, blepharitis, etc)	☐	☐	____________

Family History *(Please list relationship to patient and indicate maternal or paternal side.)* **If none, please check.**

	None		None
Blindness ____________	☐	Diabetes ____________	☐
Cataracts ____________	☐	Hypertension ____________	☐
Glaucoma ____________	☐	Heart Disease ____________	☐
Macular Degeneration ____________	☐	Stroke ____________	☐
Retinal Detachment ____________	☐	Other: ____________	☐

Social History

	Yes	No
Do you use alcoholic beverages (more than 2/day)?	☐	☐
If Yes, how much? ____________		
Do you use tobacco in any form? (Past or present)	☐	☐
If Yes, how much? Or what year did you quit? ____________		
Do you use narcotics? (prescription or recreational)	☐	☐
If Yes, which narcotic and why? ____________		

Women Only: Are you currently pregnant or nursing? **Yes** ☐ **No** ☐
If Yes, how far along are you? ____________
Or how long have you been nursing? ________

Continued on back

Cardiovascular	Yes	No
Hypertension or Heart Disease	☐	☐
Myocardial Infarction (Heart Attack)	☐	☐
Cerebrovascular Accident (Stroke)	☐	☐
Congestive Heart Failure	☐	☐
Elevated Cholesterol	☐	☐
Other ____________________	☐	☐

Constitutional	Yes	No
Disorientation	☐	☐
Dizziness or fainting	☐	☐
Weight gain/loss	☐	☐
Fever	☐	☐
Nausea	☐	☐
Other ____________________	☐	☐

Endocrine	Yes	No
Diabetes Mellitus or Insipidus	☐	☐
Hypoglycemia	☐	☐
Crohn's Disease	☐	☐
Thyroid Disorder	☐	☐
Renal Disease	☐	☐
Other ____________________	☐	☐

Gastrointestinal	Yes	No
Acid Reflux	☐	☐
Gastroesophageal Reflux (GERD)	☐	☐
Hepatic disease or Cirrhosis	☐	☐
Colitis or Ulcer	☐	☐
Inflammatory Bowel Disorder	☐	☐
Other ____________________	☐	☐

Genitourinary	Yes	No
Kidney Stones	☐	☐
Prostate Disorder/Cancer	☐	☐
Sexually Transmitted Disease	☐	☐
Uterine Cancer	☐	☐
Other ___________________	☐	☐

Head	Yes	No
Chronic Cough or Dry Mouth	☐	☐
Ear Infection or Hearing Loss	☐	☐
Headaches or Migraines	☐	☐
Sinusitis	☐	☐
Other ___________________	☐	☐

Hematologic/Lymphatic	Yes	No
Breast Carcinoma	☐	☐
Anemia or Leukemia	☐	☐
Sickle Cell Disease	☐	☐
Temporal Arteritis	☐	☐
Other __________________		

Immunologic	Yes	No
Herpes Simplex or Zoster	☐	☐
HIV Positive or AIDS	☐	☐
Histoplasmosis or Toxoplasmosis	☐	☐
Sjogren's Syndrome	☐	☐
Other: __________________	☐	☐

Integumentary	Yes	No
Acne or Rosacea	☐	☐
Albinism	☐	☐
Dermatitis or Psoriasis	☐	☐
Lupus	☐	☐
Scleroderma	☐	☐
Other __________________	☐	☐

Musculoskeletal	Yes	No
Akylosing Spondylitis	☐	☐
Arthritis	☐	☐
Down's Syndrome	☐	☐
Marfan's Syndrome	☐	☐
Osteoporosis	☐	☐
Other __________________	☐	☐

Neurological	Yes	No
Bell's Palsy	☐	☐
Horner's Syndrome	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia Gravis	☐	☐
Seizures	☐	☐
Other: __________________	☐	☐

Psychiatric	Yes	No
Attention Deficit Disorder (ADD)	☐	☐
Alzheimer's Disease	☐	☐
Anxiety Disorder or Depression	☐	☐
Autism	☐	☐
Bi-Polar Disorder or Schizophrenia	☐	☐
Other: __________________	☐	☐

Respiratory	Yes	No
Asthma	☐	☐
Bronchitis	☐	☐
COPD	☐	☐
Sarcoidosis	☐	☐
Other: __________________	☐	☐

Physician's Name:______________________________________

Are you being watched for **diabetes?** **Yes** ☐ **No** ☐

Height: _________ inches **Weight:** _________ lbs

Approximate **month/year** of **Last Physical:** ___________________

Informed consent for pupil dilation. To have a thorough eye health examination, it is necessary to dilate the pupils. Be aware that for approximately 2 to 6 hours following dilation you may notice the following: blurred vision, extreme sensitivity to light, decreased depth perception, and even feeling "off balance". If you are concerned about your ability to function or drive after dilation, and do not have anyone with you to assist you, you can request to reschedule for dilation. However, your eye examination is not complete until the internal eye health has been examined with your pupils dilated.

Consent: *I have read and understand the risk referred to above and hereby consent to having my pupils dilated today.*

______________________________	__________	______________________________	________________________________
Signature of Patient/Guardian	Date	Tech Signature	Doctor's Signature