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 ❑	Yes ❑	Diabetes	No ❑	Yes ❑
Cataract	No ❑	Yes ❑	Heart Attacks	No ❑	Yes ❑
Glaucoma	No ❑	Yes ❑	High Blood Pressure	No ❑	Yes ❑
Macular Degeneration	No ❑	Yes ❑	Thyroid Disease	No ❑	Yes ❑
Strabismus (Lazy Eye)	No ❑	Yes ❑			

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 ❑	_____