Empire Eye Physicians

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Confidential Medical History Questionnaire

Name: ______________________ Preferred Name: ______________ Date of Birth: ____________
Referring Doctor: ______________________ Spouse Name: ______________________
Family Doctor: ______________________ Home Phone: ______________ Cell Phone: ____________
Will this visit be billed to Workman's compensation? **Yes / No** Occupation: ______________________

CURRENT COMPLAINT / SYMPTOMS EVEN WITH GLASSES ON (please check)

Blur at distance	Blur at near	Blur at intermediate (computer / TV)	
Glare / Halos at night	Poor color vision	Double Vision	Different vision between eyes
Film / Haze	Eye Strain	Loss of Depth Perception	Headaches / Migraines
Floaters	Flashes	Dry Eyes	Pain / Injury
Burn / Sting	Itching / Scratchy	Allergy	Discharge / Watering
Swelling	Redness	Foreign Body	Missing / Waves in vision
Bump on / near eye			

Are the symptoms in your .... **Right / Left / Both?** How bothersome are the symptoms? **Severe / Moderate / Mild**
How long have you had the symptoms? ______________________ Are the symptoms always there? **Yes / No**
Are these symptoms affecting your lifestyle? **Yes / No** Hobbies ______________________

Have you had any injuries due to your poor vision? **Yes / No**
Explain ______________________
Do you feel as though you might sustain an injury due to your poor vision? **Yes / No**

Do you feel your vision is bothersome enough to consider a surgical procedure at this time? **Yes / No**

Would you like a new glasses prescription at this visit? **Yes / No** Do you understand our refraction policy? **Yes / No**
If you had to wear glasses, would you rather have a correction for... **Distance / Near / Both ?**
Do you currently drive? **Yes / No** Have you ever used: Plaquenil Flomax Fosamax
Do you... Smoke / Drink / Use street drugs?

Do you currently have problems with... (please check)

Skin	Neck / Back	Stomach	Lymph System	Thyroid
Head	Lungs / Breathing	Genitals / Kidney	Blood	Immune Disorders
Ears / Nose / Throat	Heart	Bones / Muscles	Stroke / Seizure	Psychiatric
Pregnant / Nursing	Liver	AIDS / HIV	Herpes / Cold Sores	Gonorrhea
Hepatitis ________	Tuberculosis	Chlamydia	Syphilis	Cancer
High Blood Pressure / How Long? ________			**Diabetic / Blood Sugar Level** ________	

Current Medications:

____
____
____
____

Drug Allergies: None
____
____

Hospitalizations / Illnesses: ______________________
____
____

OVER PLEASE →

Confidential Medical History Questionnaire (Page 2)

Eye Information

Have you ever had any of these (please check)?

Cataracts
Glaucoma
Retinal Detachment / Tear
Keratoconus
Eye Turn / Strabismus
Double Vision
Lazy Eye / Amblyopia
Trauma
Foreign Body
Herpes Simplex / Zoster
Macular Degeneration
Other ______

Surgery:

R / L Cataracts
Glaucoma
Retinal Surgery
Muscle Surgery
Corneal Transplant
Eyelid Surgery
Removal of Growth
RK / AK
PRK
LASIK
Other ______

Relatives (only those in blood relation to you)

Your Family Ocular History and their relationship to you:

Cataracts ______ Glaucoma ______ Ptosis ______
Retinal Detachment / Tear ______ Keratoconus ______ Blindness ______
Eye Turn / Strabismus ______ Lazy Eye / Amblyopia ______
Macular Degeneration ______ Other ______

Your Family Medical History and their relationship to you:

Diabetes ______ High Blood Pressure ______ Cancer ______
Arthritis ______ Kidney Disease ______ Stroke ______
Thyroid ______ Heart Attack ______ Alzheimer's ______
Other ______

Who may we thank for referring you to our clinic?
Name: ______ Relationship: ______
Address: ______

- **I HAVE LOOKED BOTH PAGES OF THIS FORM OVER AND ALL OF THE INFORMATION CONTAINED ON IT IS CORRECT TO THE BEST OF MY KNOWLEDGE.**
- **PLEASE SIGN AND DATE EACH VISIT ONCE YOU HAVE REVIEWED YOUR INFORMATION.**

Signature: ______ Date: ______ Signature: ______ Date: ______

Signature: ______ Date: ______ Signature: ______ Date: ______

Signature: ______ Date: ______ Signature: ______ Date: ______

Signature: ______ Date: ______ Signature: ______ Date: ______