Print Form

Name: Today's Date:

Occupation:

Irvine Eye Medical Group Patient History Questionnaire

NOTE: This questionnaire allows us to serve your needs better. Please answer all questions.

Medical Information

What is your general health? □ Excellent □ Good □ Fair □ Poor

Do you have problems with any of these systems? **(Please circle yes or no.)**

Gasrrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No
Diabetes	Yes/No	Type of diabetes _____		Date of diagnosis _____	

Please explain above_____

Do you smoke? Yes/No Alcohol intake? Yes, Daily/ Yes, Occasionally /No, None

Allergies to medication? **Yes/No** Which? _____

Current medications: □ None □ List here: _____

_____

_____

Have you had any operations/surgery? Yes/No Kind? _____

Name of family doctor _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Other family history _____

Personal Eye Information

Date of last eye exam _____

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Soft _____	Hard _____

Average contact lens daily wear time: □ <6 hrs □ 6-10 □ 10-14 □ 14-18 □ Overnight □ Extended wear

Average contact lens wear number of days per wk _____

Additional information _____

Doctor Use Only