Jamesburg Family Eyecare Medical Questionnaire

Last Name:_____
First Name:_____
Address:_____
City:_____
State/Zip_____
Home phone:_____
Cellphone_____
E-mail:_____
Driver License #_____
Referred by: O Patient OProfessional
Referred Name:_____
How did you hear about us?_____
_____
Race: OAsian OAfrican American
OHispanic OCaucasian/Non-Hispanic

Today's Date:_____
Sex: OMALE OFEMALE
Date of Birth:_____
SS#_____
Marital Status:_____
Employer:_____
Occupation:_____
Preferred Languauge:
OEnglish OSpanish Other:_____
Contact preference: OTelephone OE-mail
Date of last eye exam:_____
Date of last physical exam:_____
Name of primary physician:_____

PATIENT OCULAR HISTORY

Have you ever had eye surgery? YES NO
If yes, which eye was operated on R L Both
Reason for surgery:_____
Do you wear glasses: YES NO
If yes, how old is your current pair?_____
Do you wear contacts: YES NO
If yes ,how old are your contacts:_____
Type of contact lenses: Rigid Soft
Are they comfortable? YES NO

PATIENT SOCIAL HISTORY:

Do you smoke? YES NO
Do you drink alcohol? YES NO
Do you use illegal drugs? YES NO
Have you ever been infected with:
OHIV OSYPHILIS OGONORRHEA OHEPATITIS
OCHLAMYDIA OHERPES

Height:_____ Weight:_____

EYES: Do you have any of the following:

Flashes/Floaters	YES	NO	Foreign body sensation	YES	NO
Tearing/Watery eyes	YES	NO	Chronic infection of eye or lid	YES	NO
Dryness	YES	NO	Loss of side vision	YES	NO
Sandy/Gritty eyes	YES	NO	Itching	YES	NO
Lazy eye	YES	NO	Stye or chalazion	YES	NO
Crossed eyes	YES	NO	Drooping eyelid	YES	NO
Double vision	YES	NO	Sensitivity to light	YES	NO
Redness	YES	NO	Eye pain/burning	YES	NO

PATIENT MEDICAL HISTORY:

List ALL of your medical conditions: (high blood pressure, diabetes, cancer, asthma, RA, etc)?
_____
_____
_____
List ALL allergies to medications:
_____
_____

List your medications including birth control pills, eye drops and OTC medications:

REVIEW OF SYSTEMS:
Do you have problems in any of the areas below?

CONSTITUTIONAL

Fever	YES	NO
Weight loss/gain	YES	NO

NEUROLOGICAL

Headaches	YES	NO
Seizures	YES	NO
Numbness	YES	NO
Stroke	YES	NO

ENDOCRINE

Thyroid	YES	NO
Diabetes	YES	NO
Other glands	YES	NO

ALLERGIC/IMMUNOLOGIC

Lupus	YES	NO
Crohn's disease	YES	NO
Lyme disease	YES	NO

SKIN

Acne, rashes, open sores	YES	NO

EAR/NOSE/THROAT

Sinus congestion	YES	NO
Runny nose	YES	NO
Chronic cough	YES	NO
Dry mouth	YES	NO

Are you ***pregnant*** or ***nursing***? YES NO

If you answered yes to any of the above or have a condition not listed please explain below:

_____

_____

RESPIRATORY

Asthma	YES	NO
COPD	YES	NO
Emphysema	YES	NO
Bronchitis	YES	NO

CARDIOVASCULAR

Heart pain	YES	NO
Arrythmia	YES	NO
High blood pressure	YES	NO

GASTROINTESTINAL

Diarrhea/constipation	YES	NO

GENITOURINARY

Bladder, kidney, genitals	YES	NO

LYMPHATIC/HEMATOLOGIC

Anemia	YES	NO
Bleeding problem	YES	NO
Sickle cell	YES	NO

BONES/JOINTS/MUSCLES

RA, muscle/joint pain	YES	NO

PSYCHIATRIC

Mental illness	YES	NO
Depression	YES	NO
Anxiety	YES	NO

Do you have a history of cancer? YES NO
If yes, please specify location and treatment:

_____

_____

_____

FAMILY HISTORY:
Please note any family members with the following :

DISEASE			***RELATIONSHIP TO YOU*** *(SPECIFY MATERNAL OR PATERNAL)*
Blindness	YES	NO	_____
Crossed eyes	YES	NO	_____
Glaucoma	YES	NO	_____
Macular degeneration	YES	NO	_____
Retinal disease	YES	NO	_____
Arthritis	YES	NO	_____
Cancer	YES	NO	_____
Diabetes	YES	NO	_____
Kidney disease	YES	NO	_____
Heart disease	YES	NO	_____

_____ _____

Patient/Guardian Signature Date