

PATIENT HISTORY QUESTIONNAIRE

Tomoka Eye Associates

Name: _____ Date of Birth: _____

Name of Medical Doctor: _____ Last seen: _____

Allergies to Medications? (circle) **N Y Please List:** _____

Please list all major operations or hospital admissions including **eye surgeries and lasers** with approximate dates: _____

Please list **ALL** Medications you take including **eye drops and Herbal supplements:**

Name Strength How often Reason Eye (if applicable)

Family History:(please circle & list relationship)

Blindness **N Y** _____ Glaucoma **N Y** _____ Cataracts **N Y** _____
Macular Degeneration **N Y** _____ Other Hereditary Disease **N Y** _____

Social History: (please circle)

Do you drink alcohol? **N Y** How often? _____
Do you smoke tobacco? **N Y** How often? _____
Do you have a history of drug abuse? **N Y** Explain: _____

Do you drive? **N Y** Explain any visual difficulties when driving: _____

Do you have problems with night vision? **N Y** Explain: _____

Do you wear glasses? **N Y** How old is present RX? _____

Do you wear contacts? **N Y** How old is present RX? _____

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Tomoka Eye Associates

Name: _____ Date of Birth: _____

Medical History: Do you currently or have you ever had problems in the following areas?
Please circle and explain

***Eyes**

Cataracts N Y _____
 Halos around lights N Y _____
 Glare sensitivity N Y _____
 Macular Degeneration N Y _____
 Retinal Detachment N Y _____
 Diabetic damage N Y _____
 Glaucoma N Y _____
 Floaters N Y _____
 Double vision N Y _____
 Crossed eyes N Y _____
 Flashing Lights N Y _____
 "Lazy" eye N Y _____
 Drooping eyelid N Y _____
 Migraine N Y _____
 Difficulty w/new RX N Y _____
 Difficulty w/eye drops N Y _____

***Gastrointestinal**

Reflux/ Stomach ulcers N Y _____
 Colitis/ other N Y _____

***Endocrine**

Diabetes N Y _____
 Thyroid Disease N Y _____

***Neurologic**

Stroke N Y _____
 Other N Y _____

***Psychiatric**

Depression N Y _____
 Anxiety/Other N Y _____

***Ears, Nose, Throat**

Sinuses N Y _____
 Hay Fever/other N Y _____

***Bleeding Disorders**

Easy Bruising N Y _____
 Coumadin Use N Y _____
 Other Blood Thinner use N Y _____
 Blood Transfusion? N Y _____

***Cardiovascular**

High Blood Pressure N Y _____
 Heart Attack N Y _____
 Angina/Chest Pain N Y _____
 Heart Valve problems N Y _____
 Heart failure/ other N Y _____

***Immunologic**

Rheumatoid Arthritis N Y _____
 Lupus/Other N Y _____
 Acquired immunodeficiency
 Syndrome N Y _____

***Respiratory/Lung**

Asthma N Y _____
 Emphysema N Y _____
 Other N Y _____

***Other Illnesses not listed**

Date: _____ Reviewed by: _____

Doctor: _____