Bucks County Eye Group
Medical History Questionnaire

Name:____Birth date:_____/_____/_____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "YES", provide information:

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss of vision	O	O	
Loss of side vision	O	O	
Distorted vision or halos	O	O	
Fluctuating vision	O	O	
Flashes	O	O	
Floaters	O	O	
Eye pain or soreness	O	O	
Light sensitivity	O	O	
Double Vision	O	O	
Crossing or drifting of eyes	O	O	
Redness	O	O	
Discharge	O	O	
Foreign body sensation	O	O	
Sandy or gritty feeling	O	O	
Dryness	O	O	
Itching	O	O	
Burning	O	O	
Excess tearing/watering	O	O	
Glare	O	O	
Styes	O	O	
Tired eyes	O	O	
Other	O	O	
Constitutional symptoms			
Fever	O	O	
Weight loss or gain	O	O	
Fatigue	O	O	
Skin			
Rashes or color changes	O	O	
Itching or dryness	O	O	
Hair or nail changes	O	O	
Ears, nose, mouth, throat			
Hearing difficulty	O	O	
Ringing or vertigo	O	O	
Sinus congestion	O	O	
Runny nose or post-nasal drip	O	O	
Nosebleeds	O	O	
Dry throat/mouth or hoarseness	O	O	

Cardiovascular (heart/blood vessels)	**YES**	**NO**	
Chest pain or palpitations	O	O	____________________
Other__________________	O	O	____________________
Respiratory (lungs/breathing)			
Cough	O	O	____________________
Shortness of breath	O	O	____________________
Wheezing	O	O	____________________
Other__________________	O	O	____________________
Gastrointestinal			
Swallowing difficulty	O	O	____________________
Vomiting/heartburn	O	O	____________________
Diarrhea/constipation	O	O	____________________
Jaundice	O	O	____________________
Blood in stools or black stools	O	O	____________________
Genito-urinary			
Urinary frequency	O	O	____________________
Urinary pain or blood	O	O	____________________
Incontinence	O	O	____________________
Adults			
Discharge, lesions, or masses	O	O	____________________
Currently pregnant	O	O	____________________
Breast masses or discharge	O	O	____________________
Vaginal bleeding, discharge, or itching	O	O	____________________
Musculoskeletal			
Joint pain, swelling, or redness	O	O	____________________
Muscles pain or cramps	O	O	____________________
Neurological			
Headaches	O	O	____________________
Numbness or tingling	O	O	____________________
Weakness or paralysis	O	O	____________________
Fainting or blackouts			
Slurred speech	O	O	____________________
Psychiatric			
_______________	O	O	____________________
Endocrine			
Heat or cold intolerance	O	O	____________________
Excessive thirst or hunger	O	O	____________________
Hematological/lymphatics/immunology			
Easy bruising/bleeding	O	O	____________________
Blood transfusions	O	O	____________________
Swollen lymph nodes	O	O	____________________

Other symptoms not listed above____

____

PAST HISTORY

Are you allergic or have you had a reaction to the following:

	YES	NO	Reaction		YES	NO	Reaction
Local anesthetics	O	O	________	Aspirin	O	O	______
Penicillin	O	O	________	Codeine or narcotics	O	O	______
Sulfa or other antibiotics	O	O	________	Barbiturates, sedatives, or sleeping pills	O	O	______
Other	O	O	________				

Current medications (and dosage if known)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Medical history

	YES	NO		YES	NO
Asthma	O	O	Emphysema	O	O
High blood pressure	O	O	Heart disease/heart attack	O	O
Artificial heart valve	O	O	Stroke	O	O
Diabetes	O	O	Thyroid disease	O	O
Cancer	O	O	Anemia	O	O
Arthritis	O	O	Stomach ulcers	O	O
High cholesterol	O	O	Other________________________________		

Birth history (children only)

Birth weight____________ Gestational age_________________

Method of delivery O Vaginal O C-section O Forceps or vacuum

Problems during pregnancy or delivery____
____
____

Surgeries

____
____

Ocular history

Date of your last eye exam______________________ Doctor________________________

	YES	NO		YES	NO
Lazy eye	O	O	Cataract	O	O
Glaucoma	O	O	Macular degeneration	O	O
Retinal detachment	O	O	Serious eye injury	O	O
Crossed eyes	O	O	Droopy eye lid	O	O
Eye surgery	O	O	(if yes list dates, eye, and surgeon below)		

____

Other	O	O	(if yes, explain below)

____

FAMILY HISTORY

	YES	NO	Relationship		YES	NO	Relationship
Lazy eye	O	O	___________	Cataract	O	O	___________
Glaucoma	O	O	___________	Macular degeneration	O	O	___________
Retinal detachment	O	O	___________	Other______________	O	O	___________
Arthritis	O	O	___________	Cancer	O	O	___________
Diabetes	O	O	___________	Heart disease	O	O	___________
High blood pressure	O	O	___________	Kidney disease	O	O	___________
Stroke	O	O	___________	Other______________	O	O	___________

SOCIAL HISTORY

Occupation or grade in school___________________________

	YES	NO	
Do you wear glasses?	O	O	If yes, how old are your current glasses?___________________
Do you wear contact lenses?	O	O	Soft or hard or gas permeable?___________________________ Daily wear or extended wear?___________________________ Age of current contact lenses?___________________________ Method of sterilizing/product name________________

Adult patients only

Do you drink alcohol?	O	O	Drinks per day__________ *or* drinks per week_____________
Do you smoke?	O	O	Packs per day___________ Number of years_______
Do you use drugs?	O	O	
Do you drive?	O	O	
Night vision problem?	O	O	

Physician use only below

History reviewed O No changes O Additions as noted above

Physician signature____**Date**__________

Rev 12/29/04