Mary Washington Healthcare

Mary Washington Eye Care Center

# Patient History Questionnaire

Patient Name ________________________________________ Date ____________________

## Medical information

Name of your Primary Care Doctor: ________________________________________

Phone: ____________________ Fax: ________________ Date of last visit: ____________________

Referring Doctor: ________________________________________

Phone: ____________________ Fax: ________________ Date of last visit: ____________________

What is your general health? ________________________________________

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

| | | | | | |
|---|---|---|---|---|---|
| Gastrointestinal | 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 |

Please explain ________________________________________

Diabetes? Yes/No Type____________________ Date of diagnosis ____________________

Allergies to medications? Yes/No Which? ________________________________________

Reactions? ________________________________________

Other health problems ________________________________________

Current Medications ________________________________________

________________________________________

________________________________________

Have you had any surgeries? Yes/No

What/ when? ________________________________________

________________________________________

Date of last tetanus shot ____________________

## 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 _________ |

## Personal Eye History

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

Have you had any eye surgeries? 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 Type? ____________________

Do you like the contacts you are currently wearing? If not, why? ________________________________________

________________________________________

Reviewed by: ________________________________________ OD/ MD Date: ____________________