David A. Patton, O.D.
Bruce D. Gilliland, O.D.
Frank A. Carusone, O.D.

Medical History Questionnaire – please complete form to the best of your knowledge

Medical History

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation (irregular heartbeat)
- ☐ Bone marrow transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage renal disease
- ☐ GERD
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation treatment
- ☐ Other_____
  _____

Medical Surgeries

- ☐ None
- ☐ Appendix: Appendectomy
- ☐ Bladder: Cystectomy
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (right/left/both breasts)
- ☐ Breast: Mastectomy (right/left/both breasts)
- ☐ Bowel Disease
- ☐ Colon: Colectomy (Cancer resection/ Diverticulitis/Inflammatory)
- ☐ Colon: Colostomy
- ☐ Gallbladder: Cholecystectomy
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (right/left/both)
- ☐ Joint Replacement: Knee (right/left/both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liner: Shunt
- ☐ Ovaries: Oophorectomy (Endometriosis/Cancer/Cyst/ Tubal Litigation)
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Prostatectomy (Prostate Biopsy/Cancer/ TURP)
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: Hysterectomy (Fibroids/Uterine Cancer/

Eye Health History

- ☐ None
- ☐ Conjunctivitis (allergic/bacterial)
- ☐ Blepharitis (right/left/both)
- ☐ Cataract (right/left/both)
- ☐ Contact Lenses
- ☐ Corneal Dystrophy (right/left/both)
- ☐ Diabetic Retinopathy, Background (right/left/both)
- ☐ Diabetic Retinopathy, Proliferative (right/left/both)
- ☐ Dry Eyes
- ☐ Eye Infection (right/left/both)
- ☐ Glasses
- ☐ Glaucoma (right/left/both)
- ☐ Macular Degeneration (right/left/both)
- ☐ Macular ERM (right/left/both)
- ☐ Narrow Angles (right/left/both)
- ☐ Ocular Hypertension (right/left/both)
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear (right/left/both)
- ☐ Strabismus (right/left/both)
- ☐ PVD (right/left/both)
- ☐ Other_____
  _____
- ☐ If eye surgery: which eye was done & when was the surgery performed_____
  _____

Eye Surgeries

- ☐ None
- ☐ Blepharoplasty (right/left/both)
- ☐ Cataract Surgery (right/left/both)
- ☐ Corneal Transplant (right/left/both)
- ☐ DSAEK (right/left/both)
- ☐ Eye Muscle Surgery (right/left/both)
- ☐ Intravitreal Injections (right/left/both)
- ☐ LASIK (right/left/both)
- ☐ LPI (right/left/both)
- ☐ LPT (right/left/both)
- ☐ PRK (right/left/both)
- ☐ Ptosis Repair (right/left/both)
- ☐ Punctal Plugs (right/left/both)
- ☐ Strabismus Surgery (right/left/both)
- ☐ Retinal Laser (right/left/both)
- ☐ Trabeculectomy (right/left/both)
- ☐ Tube Shunt (right/left/both)

Medications

_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____

Social History

Smoking Status
- ☐ Never smoker
- ☐ Current every day smoker
- ☐ Former smoker

Drug Status
- ☐ None
- ☐ Drug use

Alcohol Status
- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Driving Status
- ☐ Not driving
- ☐ Drives in daytime
- ☐ Drives at night

Additional Details
- ☐ None
- ☐ I feel safe at home
- ☐ I do not feel safe at home

Developmental History – for pediatric patients only

Birth
- ☐ Normal
- ☐ Premature
- ☐ Low birth weight
- ☐ complications

Activity
- ☐ Normal
- ☐ Hyperactive
- ☐ Learning difficulties
- ☐ Becomes irritable

Speech
- ☐ Normal
- ☐ Difficulties
- ☐ Babbles
- ☐ Non-verbal

Motor Development
- ☐ Normal
- ☐ Reduced motor skills
- ☐ Autism
- ☐ Mentally challenged

Family History	**Mother**	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**Grandmother**	**Grandfather**	**Aunt**	**Uncle**
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal detachment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinitis Pigmentosa	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If cancer: what type & who_____

Other_____

_____

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s/technicians to examine, diagnose, and initiate treatment as deemed appropriate. I attest that I am of sound mind and in good mental health to have filled out this medical history form for myself or on behalf of the minor seeking medical services to the best of my knowledge. I further attest that I am the parent or legal guardian of the minor and have the authority to authorize care and treatment.

_____ _____ _____

Patient Name Printed | Patient/guardian's Signature | Today's Date