PACIFIC VISION MEDICAL CENTER
Health Questionnaire

Patient Name: _____ **Date:** _____

Primary Physician? _____

Were you referred to us? Y N By Whom? _____

What is the reason for today's visit? _____

MEDICATIONS: (please list all medications you are taking, including vitamins and eye drops)

_____

_____

_____

ALLERGIES: (please list any medications that you are allergic to)

_____

EYE HISTORY:

When was your last eye exam? _____ Dilated / Non-dilated ?

How old are your glasses? _____

Eye injury?..... Y N _____

Past eye problems? ..... Y N _____

(***EYE SURGERY...see back of form***)

Amblyopia (one eye weaker since childhood, even with glasses)? ..... Y N If so, Right / Left ?

PEDIATRICS: (for parents of children less than 10 years old)

Problems during pregnancy or delivery? ..... Y N
Premature delivery? ..... Y N
Problems with slow development? ..... Y N

MEDICAL HISTORY:

If you have high blood pressure: Diagnosed when? _____
Control: ◯ Good ◯ Fair ◯ Poor ◯ Unknown

If you are diabetic: Diagnosed when? _____
Average Blood Sugar: ◯ < 80 ◯ 80-120 ◯ 120-160 ◯ 160-200 ◯ 200-250 ◯ 250-300 ◯ >300

HbA1C: ◯ <6 ◯ 6-7 ◯ 7-8 ◯ 8-9 ◯ >9 ◯ Unknown

(Please complete back of form)

MEDICAL HISTORY: (do you now have or have you had?)

Arthritis	Y	N	Crohn's disease	Y	N
Congestive Heart Failure	Y	N	Ulcerative colitis	Y	N
COPD (lung disease)	Y	N	Dizziness	Y	N
Diabetes	Y	N	Seizures	Y	N
High blood pressure	Y	N	Angina	Y	N
Heart attack	Y	N	High cholesterol	Y	N
Thyroid disease	Y	N	Asthma	Y	N
Coronary heart disease	Y	N	Bronchitis	Y	N
Cancer	Y	N	Emphysema	Y	N
Stroke	Y	N	Tuberculosis	Y	N
Kidney failure	Y	N	Prostate problems	Y	N
Liver failure	Y	N	Psychiatric problems	Y	N
Weakness	Y	N	Anemia	Y	N
Weight change (+/- 15lbs)	Y	N	Hepatitis	Y	N
Sinus infections	Y	N	Hay Fever	Y	N
Vertigo	Y	N	Anesthesia reaction	Y	N
Other _____			Other _____		

PAST SURGERIES: (please list all surgeries you have had, including eye surgery and cosmetic)

_____

_____

FAMILY HISTORY:

Do any of your *blood* relatives have...			who?...
Glaucoma	Y	N	_____
Early Cataracts (before the age of 50)	Y	N	_____
Crossed or Crooked Eyes	Y	N	_____
Early Blindness	Y	N	_____
Macular Degeneration	Y	N	_____
Other serious eye problems	Y	N	_____
Heart Disease	Y	N	_____
Thyroid Disease	Y	N	_____
Diabetes	Y	N	_____

SOCIAL HISTORY:

What is your occupation? _____ Retired? Y N

Do you smoke? Y N How much? _____ For how long? _____
Do you drink? Y N How much? _____ For how long? _____

Hobbies? _____

CONSENT AND AUTHORIZATION FOR CARE:
I consent to treatment as provided or recommended by the physician and optometrist at Pacific Vision Medical Center and understand that this consent is assumed for all treatment provided or recommended unless I expressly state my desire to the contrary.

_____ Date: _____
Signature of patient or representative