WillsEye Physicians
ACADEMIC MEDICINE

Patient Name_____ Date of Birth _____

PATIENT MEDICAL HISTORY QUESTIONAIRE

Please complete these forms as thoroughly as possible

Reason for consultation / visit: _____

Do you wear glasses: yes / no

Do you wear contact lenses: yes / no

ALLERGIES

Allergen	Describe Reaction (Rash, etc.)

OCULAR (EYE) HISTORY

Disease/Problem/Surgery	Date Diagnosed	Treatment Received	By Whom

ANY OCULAR (EYE) SURGERIES NOT LISTED ABOVE? yes / no

If yes, please explain _____

MEDICAL HISTORY

Do you have environmental or food allergies? yes / no _____

Do you have chest pressure, discomfort, irregular heartbeat or palpitations? yes / no _____

Do you suffer from fatigue, fever, or night sweats? yes / no _____

Do you have an intolerance to heat or cold? yes / no _____

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Do you suffer from hearing loss? yes / no _____

Do you suffer from constipation, diarrhea, or vomiting? yes / no _____

Do you suffer from painful urination or blood in your urine? yes / no _____

Do you bruise easily? yes / no _____

Do you have any rashes or skin irritations? yes / no _____

Do you suffer from joint swelling, arthritis, or muscle weakness? yes / no _____

Do you suffer with headaches, dizziness, or gait disturbances? yes / no _____

Are you suffering from any emotional changes? yes / no _____

Do you suffer with coughing or wheezing? yes / no _____

Other medical conditions _____

OPHTHALMIC (EYE) MEDICATIONS

Medication	Strength	Dosage	Which Eye	Condition Treated

ADDITIONAL MEDICATIONS *(For example: Lisinopril, 20mg, once a day, for hypertension)*

Medication	Strength	Dosage / Frequency	Condition Treated

Pharmacy Name: _____

Pharmacy Address: _____ Fax: _____

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Are you diabetic: Yes *(please circle)* Type 1 diabetes or Type 2 diabetes

Insulin dependent: yes / no If yes, for how long: _____

Recent Blood Sugar _____ Date _____

A1C _____%_____ Date _____

No - I am not diabetic

FAMILY HISTORY

Family Member	Diagnosis

SOCIAL HISTORY

Do you smoke: yes / no / previously If yes, how long _____

Do you drink alcohol: yes / no If yes, how much / frequency _____

Do you drink caffeine: yes / no If yes, how much _____

Do you use recreational drugs: yes / no / previously

Have you had any falls in the last year: yes / no If yes, number of falls _____

If yes, did any of the falls result in injury: yes / no

_____ _____

Patient Name / Guardian / Agent Date

_____ _____

Patient / Guardian / Agent Signature Relationship