Health Questionnaire

PALMETTO HEALTH | **Ophthalmology Associates**

Patient Information

Name_____ Today's Date_____

Address_____

Referring Physician's Name_____

His / Her Address_____

Name of Patient's Primary Care Physician / Pediatrician_____

His / Her Address_____

Patient's Medical History

Please answer the following questions about your medical status:

☐ Yes ☐ No Have you ever been diagnosed with or treated for any eye or eyelid region disease, condition or injury?

☐ Cataract	☐ Glaucoma	☐ Macular Degeneration	☐ Diabetic Eye Disease
☐ Droopy Eyelid	☐ Orbital Fracture	☐ Eye or Eyelid Infection	☐ Eye or Eyelid Trauma
☐ Keratoconus	☐ Lazy Eye	☐ Fuchs' Dystrophy	☐ Blocked Tear Duct

☐ Other:_____

☐ Yes ☐ No Have you ever been diagnosed with or treated for any other medical conditions?

☐ Diabetes	☐ Hypertension	☐ Thyroid Disease	☐ Stroke
☐ Heart Disease	☐ Arthritis	☐ Multiple Sclerosis	☐ Sleep Apnea
☐ Asthma	☐ Lupus	☐ Enlarged Prostate	☐ Kidney Disease

☐ Cancer (please describe):_____

☐ Other:_____

☐ Yes ☐ No Have you ever been hospitalized for any condition not listed above?

Reason for Hospitalization	Date

Patient's Surgery History

☐ Yes ☐ No Have you had any eye surgery? Please describe and include any cosmetic and laser vision correction procedures:

Type of Eye Surgery	Date of Eye Surgery

☐ Yes ☐ No Have you had other types of surgery? Please describe:

Type of Surgery	Date of Surgery

☐ Yes ☐ No Have you had an adverse reaction to topical or general anesthesia? Please describe:

_____

_____

_____

Patient's Name_____ Today's Date_____

Vision History

☐ Yes ☐ No Do you currently wear glasses? How old are your current glasses?_____

☐ Yes ☐ No Have you ever considered laser vision correction surgery?_____

☐ Yes ☐ No Do you currently wear contact lenses? What type of lenses? ☐ Soft ☐ Rigid_____

Do you sleep in your contacts?_____

What is the brand name of your contact lenses?_____

How often do you replace your contacts (i.e., put in a new pair)?_____

Have you ever tried to wear contact lenses but were unsuccessful? Why were you unsuccessful?_____

_____

Describe your cleaning regimen:_____

Medications

☐ Check here if you have brought with you a separate list of your medications and allergies to be attached to this form. If so, you may skip this section and proceed to the SIGNATURES section below.

Please list any eye drops or other eye medications you are currently using (e.g, vitamins)?

Name of Medication / Eye Drop	Dose / Frequency	Name of Medication / Eye Drop	Dose / Frequency

Please list <u>all other medications</u> you are currently taking:

Name of Medication	Dose / Frequency	Name of Medication	Dose / Frequency

Please list your <u>medication allergies</u>:_____

_____

Signatures

I attest the information provided on this form is true and accurate, to the best of my knowledge, as of the date signed below.

_____ _____ _____

Patient / Guardian's Signature | Date | (for office use) Technician's Signature

For Office Use

PMH, ROS, RHx, SHx, Meds completed by patient / tech and reviewed by MD / DO / OD: _____ _____

Provider's Signature | Date

MD's / DO's / OD's review of medical history:

_____ _____ ☐ No Changes ☐ Changes:_____

Date | Provider's Signature

_____ _____ ☐ No Changes ☐ Changes:_____

Date | Provider's Signature

_____ _____ ☐ No Changes ☐ Changes:_____

Date | Provider's Signature