Georgetown Eye Associates

Medical History Questionnaire

Today's Date:_____

Name:_____ City:_____State_____
Address:_____ Zip Code:_____
Phone:_____ Work Phone:_____
Email Address:_____ Last Eye Exam:_____
Date of Birth:_____ Social Security #:_____
Name of Medical Doctor:_____ Dr.'s Phone Number:_____

Medical History

Do you have any allergies to medications? No Yes If yes, please explain: _____
_____

Are you allergic to latex?	No	Yes			
Have you been treated for seizures?	No	Yes			
Do you use tobacco products?	No	Yes	Former Smoker?	No	Yes
Do you use alcohol?	No	Yes			
Do you use illegal drugs?	No	Yes			

Review of Systems:

___ Alzheimer's
___ Anxiety/Depression
___ Arthritis
___ Atrial Fibrillation
___ Asthma
___ Cardiac Arrest
___ Carotid Artery Occlusion
___ Chest Pain
___ Chronic Obstructive Lung Disease
___ No current problems or disabilities
___ Congestive Heart Failure
___ Dementia
___ Diabetes Type 1
___ Diabetes Type 2
___ Endocrine System (Thyroid, Gland Disorders)
___ Eczema
___ High Cholesterol
___ High Blood Pressure

List of current medications including name, strength and what condition is being treated:

_____
_____
_____
_____
_____

Any current symptoms that you are not being treated for? Yes No
Explanation:_____

Past Ocular History:

Eye Injuries	No	Yes	Explanation_____
Cataracts	No	Yes	
Glaucoma	No	Yes	
Crossed/Lazy eyes	No	Yes	
Eye Surgeries	No	Yes	List:_____
Other			_____
Do you wear glasses	No	Yes	
Do you wear contact lenses	No	Yes	

Family Health History:
This pertains to parents, grandparents and siblings living or deceased.

Amblyopia	No	Yes	Relationship _____
Crossed Eyes	No	Yes	_____
Cataract	No	Yes	_____
Glaucoma	No	Yes	_____
Macular Degeneration	No	Yes	_____
Retinal Detachment/Disease	No	Yes	_____
Cancer	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure	No	Yes	_____
High Cholesterol	No	Yes	_____
Thyroid Disease	No	Yes	_____
Family History Unknown		Yes	