Beri Eye Care Associates, PC

Medical History Questionnaire

Name _____ **Date** _____

DOB _____

Date of last eye exam _____ Place of last eye exam _____

List any medications you *currently* take (prescription and over-the-counter):

_____ _____

_____ _____

_____ _____

Do you have any *allergies* to any medications? ____ **YES** ____ **NO**

If yes, list the medications: _____

List all *major illnesses* or *injuries*:

____ Arthritis	____ Diabetes	____ Recent Injury/Fall
____ Asthma	____ Emphysema	____ Stroke
____ Atrial Fibrillation	____ Hypertension	____ Other _____
____ Cancer	____ Heart Attack	
____ Thyroid disease	____ Kidney Failure/Dialysis	

List any *surgeries, radiation, or chemotherapy* you have had and the date:

____ Angioplasty	/ /	____ Coronary Bypass	/ /
____ Appendectomy	/ /	____ Hernia Repair	/ /
____ Cataract Extraction	/ /	____ Radiation / Chemotherapy	/ /
____ Cholecystectomy	/ /	____ Other _____	/ /

Do you *currently* have any problems in the following areas? If "Yes", please provide information.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred Vision			
Fluctuating vision			
Distorted vision (halos)			
Flashes of light/floaters			
Loss of side vision/peripheral			
Double vision			
Dryness			
Mucous discharge/pus			
Redness			
Sandy or gritty feeling			
Itching/burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes/headache			
Crossed eyes, lazy eye			
Drooping eyelid			

Patient Name: _____

PAST OCULAR HISTORY

Do you currently wear glasses?	**YES**	**NO**
Do you wear contact lenses?	**YES**	**NO**
Have you ever worn contact lenses?	**YES**	**NO**
Have you ever had prism in your glasses?	**YES**	**NO**

Have you ever had any of these:

_____ Amblyopia/lazy eye	_____ Glaucoma	Eye Surgeries/Laser treatments
_____ AMD	_____ Retinal Detachment	(Type) _____
_____ Cataract	_____ Retinal Tear	(Date) _____
_____ Floaters	_____ Diabetic Retinopathy	

REVIEW OF SYSTEMS

GENERAL/CONSTITUTIONAL	**YES**	**NO**	**Explanation of Problem**
Fever			
Weight loss, headache			
EARS, NOSE, THROAT			
sinus congestion			
CARDIOVASCULAR			
RESPIRATORY			
Shortness of breath			
Difficulty breathing while asleep			
GASTROINTESTINAL			
change in bowel habits, blood in stool			
GENITAL, KIDNEY, BLADDER			
Increased urinary frequency			
burning with urination			
MUSCLES, BONES, JOINTS			
(joint or muscles aches)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL			
numbness, weakness			
PSYCHIATRIC			
ENDOCRINE			
Increased thirst, hunger			
Heat/cold intolerance			
BLOOD/LYMPH			
fatigue, easy bruising			
ALLERGIC/IMMUNOLOGIC			
Sneezing, coughing			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Amblyopia/strabismus			
Retinal tear/detachment			
Glaucoma			
Macular Degeneration			
Blindness of unkown cause			
Migraines			
High Blood Pressure			
Diabetes			

SOCIAL HISTORY	**YES**	**NO**	
Do you drive?			
Do you live alone, w/family, foster care, other			
Do you speak English?			**If no:** What language?
Do you drink alcohol?			**If yes:** Occasional 1/day 2-3/day 4+/day
Do you smoke?			**If yes:** Occ. 1/2 pk/day 1 pk/day 1+ pk/day
Do you use any recreational drugs?			

Physician Review (initials)_____Date:_____

HISTORY REVIEWED

Physician Review (initials)_____Date:_____ Physician Review (initials)_____Date:_____

Physician Review (initials)_____Date:_____ Physician Review (initials)_____Date:_____

Physician Review (initials)_____Date:_____ Physician Review (initials)_____Date:_____