

NORTH IOWA EYE CLINIC, P.C.-Patient Medical Questionnaire

Name _____ Birthday _____ Today's Date _____

Have you ever had any **eye surgeries**? _____

Do you use any <u>eye drops</u> ? NAMES	WHICH EYE/S	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle any **eye conditions** you have:

- | | | |
|-----------------|-------------------------|-------------|
| Cataract | Inflammation in the eye | Dry eyes |
| Glaucoma | Crossed eye | Lazy eye |
| Retinal Disease | Macular Degeneration | Other _____ |

Please indicate if you have any of the following medical problems:

- Y/N Arthritis
- Y/N Diabetes What year was diagnosis made? _____
- Y/N High blood pressure If yes, how many years? _____ Is it controlled? _____
- Y/N Carotid artery surgery
- Y/N Heart Condition Explain _____
- Y/N Heart attack If so, when _____
- Y/N Bypass Surgery
- Y/N Asthma/Emphysema/COPD Are you taking treatment? _____
- Y/N Thyroid disease
- Y/N Stroke
- Y/N Cancer _____

OTHER MEDICAL CONDITIONS _____

Please List **all** of your current medications (prescription and non-prescription)

Pharmacy & Location _____

ALLERGIES TO MEDICATIONS: _____

No Allergies _____

Family Doctor & location _____ Optometrist _____

Please complete the other side too

FAMILY HISTORY

Do your parents or siblings have:

Glaucoma	Y/N
Retinal Disease	Y/N
Crossed eyes	Y/N
Lazy eye	Y/N
Cataracts	Y/N
Diabetes	Y/N
Macular Degeneration	Y/N

VISION HISTORY

Does your vision bother you to?

Watch TV	Y/N
Read printing on TV	Y/N
Read Newspaper	Y/N
Drive in the day	Y/N
Drive in the night	Y/N
See faces clearly	Y/N
See labels on medicine bottles	Y/N

SOCIAL HISTORY

Occupation
Hobbies

Do you smoke? Y/N
Do you live alone? Y/N
Do you drive a car? Y/N

Please circle those that have occurred in the last month

Constitutional:

Fever
Chills
Aching
Weight gain/loss

Ears, Nose and Throat:

Hearing loss
Ear pain
Ringing
Sore throat
Hoarseness
Sinus trouble

Cardiovascular:

Chest pain
Dizzy
Short of breath
Ankle swelling
Indigestion
Left arm pain

Respiratory:

Cough
Wheezing
Pain with breathing

Gastrointestinal:

Indigestion
Stomach pain

Change in stool
Eating disorder

**Genito-Urinary:
(Bladder/Kidney)**

Kidney stones

Musculo-Skeletal:

Joint or muscle aching
Pain/weakness

Skin:

New lump or lesion
Change of pigmented
lesion

Blood/Lymphatic:

Weakness
Anemia
Abnormal
bleeding/clotting/bruising
Lump or swelling under
arm or neck

Neurological:

Weakness
Numbness
Trouble with speech
Trouble with memory

Psychiatric:

Mood swings
Personality change
Anxiety
Depression
Sleep/eating change

Endocrine:

Skin dry/coarse
Heat intolerance
Change In energy
Significant weight
gain/loss
Excessive thirst
Frequent urination

Otherwise circle:

NONE

