OPHTHALMOLOGY ASSOCIATES P.S.C.

Medical Assessment

Name: _____ **Date of Birth:** _____ **Date:** _____

General Medical Questionnaire

Have you EVER had any of the following?

Arthritis	☐ YES	☐ NO	Emphysema	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO
Atrial Fibrillation (A-fib)	☐ YES	☐ NO	Lung Disorder	☐ YES	☐ NO
Bleeding/Clotting Disorder	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Blood Pressure Disorder	☐ YES	☐ NO	Neurological Disorder	☐ YES	☐ NO
Bowel/Stomach Problems	☐ YES	☐ NO	Psychiatric Disorder/Illness	☐ YES	☐ NO
Cardiac Pacemaker	☐ YES	☐ NO	Pulmonary Embolism/DVT	☐ YES	☐ NO
Cardiac Stent	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Cholesterol Disorder	☐ YES	☐ NO	Seizure or Epilepsy	☐ YES	☐ NO
Chronic Headaches	☐ YES	☐ NO	Thyroid Disorder	☐ YES	☐ NO
COPD	☐ YES	☐ NO	Urinary/Kidney Disorder	☐ YES	☐ NO

Diabetes ☐ YES ☐ NO ☐ Medication/Diet only ☐ Currently using insulin

Cancer ☐ YES ☐ NO Type: _____

Please list any other medical illness or problems and provide details for any of the above conditions:

_____

_____

_____

Please list all past surgeries and hospitalizations and the approximate date

Procedure/Hospitalization	Date	Complications

Social History

Do you currently smoke? ☐ YES ☐ NO If no, have you ever smoked? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO

Do you use drugs? ☐ YES ☐ NO

Do you live by yourself? ☐ YES ☐ NO If no, who do you live with? _____

Do you drive? ☐ YES ☐ NO If your vision drops to 20/60 or less, you are not legal to drive

What IS/WAS your occupation? _____

Hobbies: _____

Updated June 2018

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Family History

Please indicate if members of your immediate family have EVER had any of the following:

Condition	Relatives
Glaucoma	
Macular degeneration	
Diabetes	
Heart Disease	
Thyroid Disease	
Stroke	

Allergies and Current Medicines

Do you have any allergies to medications? ☐ Y ☐ N Do you have a Latex allergy? ☐ Y ☐ N

If yes, please list allergies and reactions

Allergy	Reaction

Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, etc.

Pharmacy _____ Phone # _____ Address _____

Who is your primary care physician? _____

Who referred you to our practice? _____

Other doctors taking care of you? _____

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