

Name Mr. Test Record

Date Feb 6, 2004

Piedmont EyeCare Associates, OD, PLLC

MEDICAL HISTORY QUESTIONNAIRE

EYE HISTORY

- Headaches, Glare/Light Sensitivity, Tired Eyes, Lazy Eye, Burning, Dryness, Excess Tearing/Watering, Eye Pain or Soreness, Foreign Body Sensation, Infection of Eye or Lid, Itching, Mucous Discharge, Blurred Vision Distance, Blurred Vision Near, Distorted Vision (halos), Double Vision, Floaters or Spots, Fluctuating Vision, Loss of Vision, Loss of Side Vision, Drooping Eyelid, Redness, Sandy or Gritty Feeling, Crossed Eyes

GENERAL HEALTH CONDITION

- Fever, Weight Loss, Other Consti. Symptoms, Ears, Nose, Throat, high blood pressure, Respiratory (Asthma), Gastrointestinal, Psychiatric, Kidney, Muscles, Bones, Joints, Skin, Neurological (MS), Anxiety, Depression, Insomnia, Diabetes, thyroid, Blood/Lymph (cholesterol), Allergic/Immunologic

Past Illnesses or Injuries: _____

Past Surgeries: _____

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

FAMILY HISTORY

- Lazy Eye, Blindness, Cataract(s), Color Blindness, Glaucoma, Macular Degeneration, Retinal Detachment, Eye Turn, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Stroke, Thyroid Disease, Others