MEDICAL HISTORY QUESTIONAIRE

STERLING EYE CENTER, L.L.P.

220 S. 3rd St., Suite 1, Sterling, CO 80751 - 970-522-1833

Daniel H. Sharp, M.D./William S. Buchanan, M.D.

TODAY'S DATE: ________________

PATIENT NAME: __________________________ SEX: __ AGE: ___ DATE OF BIRTH: __________

FAMILY PHYSICIAN: __________________________________

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer.

Current eye problem or reason for visit: ____

____

OCULAR HISTORY

Have you ever had any eye disease, surgery or injury? NO____ YES ____

If yes, please describe including dates and the name of the doctor who treated you.

Date **Doctor** **Description**

____
____
____

Have you ever worn glasses or contact lenses? NO ____ YES ____

If yes, how old is your glasses or contact lens prescription? ____________

MEDICAL HISTORY

Have you ever had surgery anywhere on your body, in your whole life? NO ____ YES ____

If yes, please describe: ____

____

MEDICATION

Please list any medication you currently take, *prescription and over-the-counter*.

____

____

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

If yes, please list medications:____

____

SOCIAL HISTORY

With your current glasses or contact lenses, does your vision make it difficult for you to :

	Read?	NO ____ YES ____
	Write?	NO ____ YES ____
	Drive?	NO ____ YES ____
	Cook?	NO ____ YES ____
	Sew?	NO ____ YES ____
	Watch TV?	NO ____ YES ____
	Work?	NO ____ YES ____
Do you:	Smoke?	NO ____ YES ____
	Chew Tobacco?	NO ____ YES ____
	Drink Alcohol?	NO ____ YES ____
	Use Drugs?	NO ____ YES ____

REVIEW OF SYSTEMS

Do you have any problem in the following areas? If yes, please explain.

Cancer	NO ____ YES ____ -	____
Diabetes	NO ____ YES ____ -	____
Thyroid	NO ____ YES ____ -	____

High Blood Pressure NO ____ YES ____ - ____

Lungs/Breathing NO ____ YES ____ - ____

Heart Disease NO ____ YES ____ - ____

Tuberculosis NO ____ YES ____ - ____

Headaches NO ____ YES ____ - ____

Skin NO ____ YES ____ - ____

Genitals, Kidney, Bladder NO ____ YES ____ - ____

Bones, Joints, Muscles NO ____ YES ____ - ____

Blood (HIV positive, Hepatitis) NO ___ YES ____ - ____

Psychiatric NO ____ YES ____ - ____

FAMILY HISTORY

Has *ANYONE* in your family besides you (such as, parents, grandparents, siblings, children) had any of the following?

Cancer NO ____ YES ____ WHO: ___________ TYPE: ________________

Tuberculosis NO ____ YES ____ WHO: ___________ TYPE: ________________

Diabetes NO ____ YES ____ WHO: ___________ TYPE: ________________

High Blood Pressure NO ____ YES ____ WHO: ___________ TYPE: ________________

Heart Disease NO ____ YES ____ WHO: __________ TYPE: ________________

(Such as: heart attack, stent, angioplasty, by-pass surgery, hardening of arteries)

Eye Disease NO ____ YES ____ WHO: ___________ TYPE: ________________

(Such as: glaucoma, macular degeneration, cataracts, retinal detachment, lazy eye)

____ ____________________

Patient or legally authorized signature Date

Relationship (parent, legal guardian, personal representative, etc.) _________________________