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Beaumont Medical Building • 1455 S. Lapeer Rd., Suite 110 • Lake Orion, Michigan 48360 • (248) 814-7139

~ PLEASE PRINT ~

PATIENT HISTORY QUESTIONNAIRE

NAME: _____

PLEASE FILL OUT BOTH SIDES OF FORM COMPLETELY

1. Why are you seeing the doctor today? _____

2. How long has this condition existed? _____

3. Please check if you are experiencing any:

Yes No

- Eye Pain
- Straight Lines Appear Crooked
- Itchy/Watery Eyes
- Headaches
- Problems Walking Due to Vision
- Problems Watching TV or Driving with Current Glasses

Yes No

- Light Flashes
- Blurred Vision
- Difficulty With Night Vision
- Sinus/Nasal Congestion
- Difficulty Working Due to Vision
- Difficulty Reading/Writing with Current Glasses

Other: _____

4. Please list all medications you currently take & dosage (include eye & general medications)

5. Please list all ALLERGIES & reactions to medications (include eye & general medications)

6. Please list all previous surgery & dates (include eye & general surgeries)

PLEASE TURN FORM OVER AND FILL OUT OTHER SIDE...THANKS

7. Do you have a history of any of the following:

- | | | |
|--------------------------|--------------------------|-------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble/Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems/Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems/Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss/Depression |

- | | | |
|--------------------------|--------------------------|-----------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Closed Head Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease/Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Aids/Exposure to Aids |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever/Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: |

8. Do any of your relatives have:

- | | | |
|--------------------------|--------------------------|----------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Detached Retina |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinitis Pigmentosa |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataract |
| <input type="checkbox"/> | <input type="checkbox"/> | Lazy Eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Other |

Relationship

9. Is there any family history of:

- | | | |
|--------------------------|--------------------------|---------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease/Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |

10. Do you currently:

- | | | |
|--------------------------|--------------------------|---------------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Use Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> | Drink 1-3 alcoholic beverages per day |
| <input type="checkbox"/> | <input type="checkbox"/> | Use Non-Prescribed Medications |

11. Please list all doctors who should receive a report of your examination (include address if the doctor is not affiliated with Beaumont). If you have a Primary Care Physician, please indicate his/her name and address.

THANK YOU FOR ANSWERING EVERY QUESTION ON THIS FORM!

All the information given above is true to my knowledge,

Patient Signature

Date

Parent Signature (if minor)

Date

Physician Signature/Teaching Physician Signature

Date