NAME:_____DATE OF BIRTH:_____TODAY'S DATE: _____
OCCUPATION:_____
Primary Care Physician: _____
If you were referred to Springfield Eye Associates, who may we thank? _____

PLEASE COMPLETE THIS CONFIDENTIAL GENERAL MEDICAL QUESTIONNAIRE

PAST MEDICAL HISTORY:

Asthma/COPD …… □ Y □ N
Arthritis/R.A. …… □ Y □ N
Bleeding/Clotting/Blood Disorder …… □ Y □ N
Diabetes (Type I or II) …… □ Y □ N
G.I. Problems (GERD, Crohn's, other) …… □ Y □ N
Cancer…… □ Y □ N
High Cholesterol …… □ Y □ N
Eye Condition (glaucoma, cataracts, other) . □ Y □ N
Hypertension/Heart Disease …. □ Y □ N
Lupus/Autoimmune Disease …. □ Y □ N
Migraines …… □ Y □ N
Stroke/T.I.A. …… □ Y □ N
Thyroid (hyper/hypo)…… □ Y □ N
Seizure or Epilepsy…… □ Y □ N
Kidney Disease …… □ Y □ N
Skin Condition (Rosacea, other). □ Y □ N

ALLERGIES:

Do you have any allergies to medication or other substances (pets, food, etc.)? □ Y □ N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

MEDICATIONS:

Please list **ALL** of your current medications, including over-the-counter medications, supplements, and herbs:

Medication	Medication	Medication	Medication

Please list ALL EYE DROPS THAT YOU ARE USING: (including over-the-counter drops)

1._____; 2. _____; 3. _____; 4. _____
5. _____; 6. _____; 7. _____; 8. _____

FAMILY MEDICAL HISTORY: Diabetes, Glaucoma, Macular Degeneration, Retinal Detachment, Cancer, High Blood Pressure, Stroke, Heart Attack, Arthritis, Strabismus (crossing eyes) or any other condition:

Relative	Condition	Living	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you currently Smoke? □ Y □ N If NO, Previously? □ Y □ N Years Smoked? _____ Packs/Day: _____
Do you drive? Daytime? / Nighttime? □ Y □ N Do you exercise? □ Y □ N Weight: Gain / Loss / Stable
Do you use other Tobacco Products? □ Y □ N Consume alcohol? □ Y □ N Drinks/Week? _____

_____ Reviewed By: _____
Patient Signature Staff Initials