



SILICON VALLEY EYE PHYSICIANS

General Health and Medical Questionnaire

Date: _____ Name: _____

Age: ____ DOB: ____ / ____ / ____ Sex: M or F Primary Care Physician: _____

Occupation: _____ New Patients: Date Of Last Eye Exam _____

PATIENT HISTORY

Are you allergic to any medications? Yes or No (If yes, specify) _____

List any medications: include all prescriptions and non-prescriptions (ex: aspirin)? _____

List all major illnesses or injuries (glaucoma, diabetes, high blood pressure, heart attack, concussion, etc.) _____

List any surgeries you have had: (cataract, appendectomy) _____

Have you ever had a blood transfusion? Yes No Do you wear glasses? Yes No Contacts? Yes No

Table with 4 columns: Do you have problems in the following areas?, No, Yes, Details. Rows include Eyes, Females, General Constitution, Ears, Nose, Throat, Cardiovascular, Respiratory, Gastrointestinal, Genital, Kidney, Bladder, Muscles, Bones, Joints, Skin, Neurological, Psychiatric, Endocrine, Blood, Lymph, Allergic, Immunologic.

FAMILY HISTORY

Has any member of your family had any of these diseases? (circle all that apply) Yes No Unknown Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other inheritable disease:

SOCIAL HISTORY

Does your vision limit any daily living (driving, reading, sports, work, hobbies, etc.)? Yes No Do you drink alcohol? No Yes occasional 1 day 2-3 day 4+ day Do you smoke? No Yes occasional 1/2 pack day 1 pack day 1+ pack day