Physician's Eye Care & Laser Center

BALTIMORE: 410-644-9515
COLUMBIA: 410-964-8285
ELLICOTT CITY: 410-480-9966

CURRENT HEALTH HISTORY AND QUESTIONNAIRE

Name _____ **Male** O **Female** O **D.O.B.** _____ **Date** _____

Family Doctor _____ **Doctors Phone Number** _____

Date of last exam (if known) _____ **Occupation** _____

Chief Complaint/Reason for Visit _____

Height _____ **Weight** _____ **Blood Pressure** _____

Current Medications _____

_____

Allergies to Medications? O **Yes** O **No (If yes, list all medications you're allergic to)** _____

_____

	Yes	No
Asthma	O	O
Arthritis	O	O
Tuberculosis	O	O
Diabetes IDDM/Type II_____# yrs.	O	O
Psychiatric Disorder	O	O
Migraines	O	O
Heart Disease	O	O
Ulcer	O	O
High Blood Pressure_____# yrs.	O	O
Sickle Cell Anemia	O	O
Seizure, Convulsions, Fainting	O	O
Temporal Arteritis	O	O
Carotid Artery Disease	O	O
Stroke	O	O
HIV	O	O
Thyroid Disease	O	O
Cholesterol	O	O
Kidney Disease	O	O

Preferred Pharmacy _____

Do you Drive? _____ **Do you live alone?** _____

Do you drink alcohol? _____

MARITAL STATUS: O Married O Single O Widowed O Divorced

RACE: O White O Asian O African American O American Indian
O Alaskan Native O Native Hawaiian or other Pacific Islander
O Hispanic O Other_____

HOW DID YOU HEAR ABOUT US: O Walk-In O Internet
O Word of Mouth O Print Advertising O Insurance Company

COMMUNICATION PREFERENCE: O Letter O Phone
O E-Mail (please provide) _____

LANGUAGE PREFERENCE: O English O Japanese O French
O Italian O Portuguese O Spanish O Russian

OCULAR HISTORY (Have you been diagnosed with any of the following in the past)

	Yes	No		Yes	No		Yes	No
Cataracts	O	O	Corneal Disease	O	O	Contact Lens_____	O	O
Retinal Disease	O	O	Glaucoma	O	O	Brand_____		
Iritis	O	O	Injury	O	O	Other Eye Diseases_____		

Lasik Surgery (Date of Surgery)_____ O Right O Left _____

Cataract Surgery O Right_____ O Left_____

Do you have a Lens Implant? O Yes O No Retinal Surgery? O Right_____ O Left_____

FAMILY HISTORY (Have any of your blood relatives had any of the following? If so please specify.)

	Yes	No		Yes	No
Glaucoma _____	O	O	Diabetes _____	O	O
Cataracts _____	O	O	Heart Conditions_____	O	O
Corneal Disease _____	O	O	Diabetic Retinopathy _____	O	O
Macular Degeneration _____	O	O	Retinal Detachment _____	O	O
Retinitis Pigmentosa_____	O	O	Stroke _____	O	O
Other Eye Problems _____	O	O	Other Health Problems _____	O	O

SURGICAL HISTORY/OTHER MEDICAL DISEASES (Please indicate date and type) _____

_____

_____ _____

TECHNICIAN SIGNATURE **DOCTORS SIGNATURE**