

GULF BREEZE EYE CARE

Suzanne M. Day, O.D., INC.
97 Baybridge Drive Gulf Breeze, FL 32561

Ocular and Medical History Questionnaire

Name: _____ DOB: _____

OCULAR HISTORY:

Last eye exam: _____ Doctor: _____

I currently wear: Glasses Contact lenses No correction

CHECK ANY OF THE FOLLOWING THAT APPLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Itching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Light sensitive |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Wavy lines |

	YOU	FAMILY MEMBER
Blindness	<input type="checkbox"/>	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/> _____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> _____
Crossed eye	<input type="checkbox"/>	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/> _____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/> _____

Permanent Eye Injury: _____

Eye Surgery: _____

Eye Drops: _____

(RX and over-the-counter)

Do you wear contact lenses? ____ Would you like to try contact lenses? ____

If you wear contact lenses please answer the following:

Brand of contact lens _____ Disinfection solution _____

Do you sleep in your lenses? Y N How many consecutive nights? _____

How often do you throw your lenses away? _____

OVER>

PATIENT NAME: _____ **MEDICAL HISTORY PAGE 2**

Family physician: _____ Date of last exam: _____

List all medications or over the counter remedies you are currently taking: _____

List all allergies: _____

Medication allergies: _____

PLEASE CHECK ALL THAT APPLY:

General health: good fair poor

	No	Yes	Family member (if so who?)
Ear, nose, throat disorder	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> _____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Gastro-intestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Blood/ lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Allergies or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	
Aids or HIV +	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnant	<input type="checkbox"/>	<input type="checkbox"/> # months _____	

All vision service plan patients are required to complete the following:

Do You Use: Cigarettes? No Yes #/day ___ Alcohol? No Yes #/day ___

Recreational Drugs? No Yes

Do you use a computer? No Yes #hours per day: _____

Review of systems completed: _____ Date: _____

Updated: _____ / _____ / _____ / _____ / _____
Doctor's signature