Blanchard Eye Care

Dr. Vincent M. Young, O.D.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Last name: _____First Name: _____ MI: _____
Preferred Name: _____
Mailing Address: _____
City: _____State: _____ Zip: _____
Telephone (cell/home/work): _____ (cell/home/work): _____
SSN: _____ DOB: _____Marital Status: _____
Occupation: _____Employer:_____Employment Status: _____
Emergency contact/Telephone Number: _____
Date of last exam, if not here: _____Where/Telephone: _____Dilated: Yes or No
Name of family doctor: _____Telephone: _____
Whom may we thank for referring you? _____

Patient History

Diabetes: Y/N Type: _____ Date of Diagnosis: _____
Do you have: Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Headaches? Y/N
Any ocular or medical operations? Y/N Describe: _____
Current Medication(s): _____
Medication Allergy: Y/N Please list and describe: _____
Allergies(non-medication): Y/N Please list and describe: _____
Date of last tetanus shot: _____

Family History

Cataracts	Y/N	Relation_____	Macular degeneration	Y/N	Relation_____
Diabetes	Y/N	Relation _____	Retinal detachment	Y/N	Relation_____
Glaucoma	Y/N	Relation _____	High blood pressure	Y/N	Relation _____
Other condition(s)	Y/N	What kind? _____			

Social History

Do you use tobacco? Y/N Smokeless tobacco? Y/N Pack(s) per day? ____ If quit, how long ago? _____
Alcohol? Y/N Frequency?_____ Other Substance(s)? _____

Vision

Do you wear glasses? Y/N Type: Single Vision/Bifocal/No-Line Bifocal
Contact lenses? Y/N Brand: _____

Review of Systems

Do you have problems with any of these symptoms? **(Please circle your response and give explanation)**

Allergy	Y/N	Genitourinary	Y/N	Musculoskeletal	Y/N
Cardiovascular	Y/N	Head	Y/N	Neurological	Y/N
Digestive	Y/N	Hematological	Y/N	Psychiatric	Y/N
Endocrine	Y/N	Immunological	Y/N	Respiratory	Y/N
Gastrointestinal	Y/N	Integumentary	Y/N		

Please Explain: _____
Other health problems: _____
Additional Information: _____

Patient/Guardian Signature: _____Date: _____