POPE EYE CARE HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F			**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary Care Physician:		**Pharmacy:**	
Social Security Number:		**Age:**	
Address:	**City:**	**State:**	**Zip Code:**
E-mail:			
Please check the box next to the number you prefer to have called first:			
☐ **Home Phone:**	☐ **Cell Phone:**	☐ **Work Phone:**	

PERSONAL HEALTH HISTORY

What is the main reason for today's exam? :		
When was your last eye exam? :	**Health exam? :**	
Height:	**Weight:**	**Average Blood Pressure:**
Current eye drops:		

List all surgeries that are eye related below:		
Year	Reason	Doctor

Other Surgeries:		
Year	Reason	Hospital

List your prescribed medications below:			
Name the Medication	Strength	Name the Medication	Strength

Allergies to medications:	
Name the Drug	Reaction You Had

CURRENT EYE WEAR							
Contacts	Are you interested in getting contacts at today's visit?					☐ Yes	☐ No
	Do you currently wear contacts?					☐ Yes	☐ No
	If yes, what brand/RX are you wearing?						
Glasses	How old is your current pair of glasses?						
PLEASE ANSWER ACCORDING TO YOUR CURRENT HEALTH:							
OCULAR HEALTH	Glaucoma	☐ Yes	☐ No	NEUROLOGICAL	Multiple Sclerosis	☐ Yes	☐ No
	Cataract(s)	☐ Yes	☐ No		Epilepsy	☐ Yes	☐ No
	Macular Degeneration	☐ Yes	☐ No		Alzheimer's	☐ Yes	☐ No
	Blurry vision	☐ Yes	☐ No		Parkinson's	☐ Yes	☐ No
	Double vision	☐ Yes	☐ No		Cerebrovascular	☐ Yes	☐ No
OTHER:							
MUSCULOSKELETAL	Fibromyalgia	☐ Yes	☐ No	PSYCHIATRIC	Depression	☐ Yes	☐ No
	Muscular Dystrophy	☐ Yes	☐ No		Panic Disorder	☐ Yes	☐ No
	Osteoarthritis	☐ Yes	☐ No		Schizophrenia	☐ Yes	☐ No
OTHER:							
GASTROINTESTINAL	Colitis	☐ Yes	☐ No	HEMATOLOGIC/ LYMPHATIC	Anemia	☐ Yes	☐ No
	Ulcer	☐ Yes	☐ No		Large blood volume loss	☐ Yes	☐ No
	Digestive	☐ Yes	☐ No		Leukemia	☐ Yes	☐ No
OTHER:							
CONSTITUTIONAL	Developmental Disability	☐ Yes	☐ No	EAR, NOSE, MOUTH, & THROAT	Upper Respiratory Tract Infection	☐ Yes	☐ No
	Weight Loss	☐ Yes	☐ No		Ear Ache	☐ Yes	☐ No
	Fever	☐ Yes	☐ No		Runny Nose	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No		Sore Throat	☐ Yes	☐ No
	Trauma	☐ Yes	☐ No		Ringing	☐ Yes	☐ No
OTHER:							
CARDIOVASCULAR	Heart Disease	☐ Yes	☐ No	RESPIRATORY	Smoking Status	☐ Yes	☐ No
	Hypertension	☐ Yes	☐ No		Asthma	☐ Yes	☐ No
	Stroke	☐ Yes	☐ No		Bronchitis	☐ Yes	☐ No
	Vascular Disease	☐ Yes	☐ No		Emphysema	☐ Yes	☐ No
OTHER:							
ALLERGIC	Arthritis	☐ Yes	☐ No	GENITOURINARY	STD, viral herpes	☐ Yes	☐ No
	Lupus	☐ Yes	☐ No				
OTHER:							
ENDOCRINE	Non-Insulin Diabetes	☐ Yes	☐ No	INTEGUMENTARY	Eczema	☐ Yes	☐ No
	Insulin Diabetes	☐ Yes	☐ No		Rosacea	☐ Yes	☐ No
	Thyroid Dysfunction	☐ Yes	☐ No		Psoriasis	☐ Yes	☐ No
	Hormonal Dysfunction	☐ Yes	☐ No				
IF YOU ARE A DIABETIC, PLEASE ANSWER THE FOLLOWING QUESTIONS:							
How long have you been a diabetic?		What is your average blood sugar?		How often do you check it?			

FAMILY MEDICAL HISTORY

Does anyone in your family have one of the following? If yes, who? (father, mother, grandmother, etc…)			
Glaucoma?	☐ Yes	☐ No	
Cataract(s)?	☐ Yes	☐ No	
Macular Degeneration?	☐ Yes	☐ No	
Hypertension?	☐ Yes	☐ No	
Diabetes?	☐ Yes	☐ No	