Putnam Vision Center **Patient Medical History** **Date: ___/____/ ____**

Patient Name:

General Status

Name of Primary Medical Doctor: _____ Doctor's Phone Number: (_____) _____- _____

Last Visit to Primary Medical Doctor: ____/____/_____ Reason for last visit: _____

Ocular/Eye History *(If you are a current patient of the practice, please skip to patient current symptoms)

Last Eye Exam: _____/_____/_____ Last eye exam Doctor: _____
Do you wear glasses? __No ___Yes If yes, how old is your current pair of lenses? _____
Do you wear contact lenses? __No __ Yes If yes, how old is your current pair of lenses? _____
Current type of contact lenses: __Rigid __ Soft __ Extended Wear __ Other (please List): _____
Are your contacts comfortable? __No __Yes
Have you ever had Lasik surgery? __No __ Yes If yes, where and when? _____
Do you drive? __No __Yes If yes, do you have visual difficulty when driving? __No __Yes If yes, please describe: _____

***Patient Current Symptoms**

Do you **currently** have problems in the following areas:

	No	Yes	?		No	Yes	?
Loss of Vision	__	__	__	Prominent Eyes	__	__	__
Loss of Side Vision	__	__	__	Dryness	__	__	__
Distorted Vision/Halos	__	__	__	Double Vision	__	__	__
Mucous Discharge	__	__	__	Light Sensitivity/Glare	__	__	__
Sandy or Gritty Feeling	__	__	__	Lazy Eyes	__	__	__
Burning	__	__	__	Drooping eyelid	__	__	__
Foreign Body Sensation	__	__	__	Eye Infection	__	__	__
Excess Tearing/Watering	__	__	__	Itching	__	__	__
Eye Pain or Soreness	__	__	__	Crossed Eyes	__	__	__
Redness	__	__	__	Chronic Infection of Eye or Lid	__	__	__
Blurred Vision	__	__	__	Sties or Chalazion	__	__	__
Flashes/ Floaters in Vision	__	__	__	Tired Eyes	__	__	__

Review of Systems *****Height: _____ Weight: _____ Blood Pressure:____/____**

Do **you** currently, or have you ever had any problems in the following areas:

	No	Yes	?		No	Yes	?
Constitutional				**Musculoskeletal**			
Fever, Weight Loss/Gain	__	__	__	Rheumatoid Arthritis	__	__	__
Cardiovascular				Muscle Pain	__	__	__
Heart Pain	__	__	__	Joint Pain	__	__	__
Heart Disease	__	__	__	**Integumentary (Skin)**	__	__	__
High Blood Pressure	__	__	__	**Neurological**			
Vascular Disease	__	__	__	Headaches	__	__	__
Ears, Nose, Mouth, Throat				Migraines	__	__	__
Allergies/Hay Fever	__	__	__	Seizures	__	__	__
Sinus Congestion	__	__	__	**Psychiatric**	__	__	__
Runny Nose	__	__	__	**Endocrine**	__	__	__
Post-Nasal Drip	__	__	__	Bleeding Problems	__	__	__
Chronic Cough	__	__	__	Thyroid/ Other Glands	__	__	__
Dry throat/Mouth	__	__	__	**Allergic/Immunologic**	__	__	__
Respiratory				**Hematologic/Lymphatic**	__	__	__
Asthma	__	__	__	Anemia	__	__	__
Chronic Bronchitis	__	__	__	Diabetes	__	__	__
Emphysema	__	__	__	**If yes for Diabetes, Please complete following:**			
Gastrointestinal				Type I ___ Type II ___			
Diarrhea	__	__	__	Last BS results? _____ Self Tested __No __Yes			
Constipation	__	__	__	Last A1C Blood work Date _____			
Genitourinary				Last A1C results _____			
Genitals/Kidney/Bladder	__	__	__	**Pregnant**	__	__	__

If you answered **yes** to any of the above or have a condition not listed, please explain: _____
_____(continued on back side)
Do you work on a Computer? __Yes __No If so, how many hours daily? _____

Surgical History

List all major injuries, surgeries and/or hospitalizations with dates: _____
_____

Past/Present Ocular History Do **you** currently, or have you ever had any problems in the following areas:

	No	Yes	?		No	Yes	?
Glaucoma	__	__	__	Blindness	__	__	__
Cataract	__	__	__	Strabismus	__	__	__
ARMD(Macular Degeneration)	__	__	__	Amblyopia	__	__	__
Eye Injury	__	__	__	Dry Eye	__	__	__
Retinal Disease	__	__	__	Other Eye Conditions	__	__	__

Family History Please note **any** family history for the following reasons:(MGM, MGF=mother's side, PGM,PGF=father's side)

Disease/Condition	None	Mother	MGM	MGF	Father	PGM	PGF	Sister	Brother	Uncle	Aunt
Glaucoma	__	__	___	___	____	___	___	___	___	___	___
Cataract	__	__	___	___	____	___	___	___	___	___	___
ARMD (Macular Degeneration)	__	__	___	___	____	___	___	___	___	___	___
Eye Injury	__	__	___	___	____	___	___	___	___	___	___
Crossed Eyes	__	__	___	___	____	___	___	___	___	___	___
Retinal Detachment/Disease	__	__	___	___	____	___	___	___	___	___	___
Blindness	__	__	___	___	____	___	___	___	___	___	___
Strabismus	__	__	___	___	____	___	___	___	___	___	___
Amblyopia	__	__	___	___	____	___	___	___	___	___	___
Diabetes	__	__	___	___	____	___	___	___	___	___	___
Cancer	__	__	___	___	____	___	___	___	___	___	___
Heart Disease	__	__	___	___	____	___	___	___	___	___	___
Kidney Disease	__	__	___	___	____	___	___	___	___	___	___
Thyroid Disease	__	__	___	___	____	___	___	___	___	___	___
Lupus	__	__	___	___	____	___	___	___	___	___	___
High Blood Pressure	__	__	___	___	____	___	___	___	___	___	___

Other (please list) _____

Social History **This information is kept strictly confidential. However, you may discuss this portion with your doctor if you prefer. ___YES, I would prefer to discuss my Social History information directly with my doctor.**

Do you currently use Tobacco products?__ No __Yes If yes, type/amount/how long?_____
If you do not currently use Tobacco products, have you ever used Tobacco products? __No __Yes
Do you drink alcohol? __No __Yes If yes, type/amount/how long? _____
Do you use illegal drugs? __No __Yes If yes, type/amount/how long? _____
Have you ever been exposed to or infected with any of the following:__ No __Yes __ Gonorrhea __ Hepatitis __HIV __Syphilis

Medications and Allergies

List any medications you take(including oral contraceptive, aspirin, over the counter medications and home remedies):_____
_____
_____

Do you have any allergies to medicine? __ No __Yes If yes, explain reaction: _____
_____
_____

Reviewed by Dr. David B. Gaudreau: _____ Updated:____/____/____

Putnam Vision Center Patient Demographic Questionnaire **Date: _____/_____/20___**

Name: _____**Sex**: ____Male ___Female **Salutation**: (circle one) Mr. Mrs. Ms. Miss Dr.

Birth Date: ____/____/_____ Birth State: ____ **Social Security#**: _____/____/_____

Mailing Address: _____ **Primary Language**:_____

_____

Special Needs: ___Wheelchair ___ Translator __Hearing Impaired __None

Communication Preference (check box):___Home __Cell ___Work __ Email __ Text __ US Mail

Home Phone: (_____) _____- _____ **Work Phone**: (_____) _____- _____

Cell Phone: (_____) _____- _____ **Cell Phone Carrier Company**: ___AT&T __ Verizon

Email Address: _____ Other:_____

Race: _____ **Ethnicity**: ___Unknown ___Hispanic __ Non Hispanic

Employer: _____ **Occupation**: _____

Mother's Maiden Name: _____

Account Responsible ___(check here if patient is responsible)

Name: _____

Relationship to patient: _____ SS#: _____ DOB: __/___/_____

Address if different than above: _____

Phone number: (_____) _____- _____ Email address: _____

Emergency Contact Person

Name: _____ Relationship to patient:_____

Address if different than above: _____

Home Phone: (_____) _____- _____ Cell: (_____) _____- _____