

SETH A. BISER, M.D., P.C. - FLEETWOOD OPHTHALMOLOGY - HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

GENERAL MEDICAL QUESTIONS

Drug Allergies , or drugs you cannot take for any other reason (e.g., side effects). Please list the drug(s) and reaction(s): <div style="text-align: right;"><input type="checkbox"/> I am not aware of any drug allergies</div>					
Current Medications: prescription, over-the-counter, vitamins, and supplements: <div style="text-align: right;"><input type="checkbox"/> I take no medications</div>					
Medical Problems/History. <input type="checkbox"/> Currently pregnant? <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack or Heart Failure <input type="checkbox"/> Asthma / COPD <input type="checkbox"/> Cancer <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> HIV Other – Please Write In:					
Major Surgeries. Please list, and include dates:					
Family History. Check any blood relatives with:	NONE	Mother	Father	Sibling	Grandparent
Glaucoma	<input type="checkbox"/>				
Macular Degeneration	<input type="checkbox"/>				
Retinal Detachment	<input type="checkbox"/>				
Blindness (of other or unknown cause)	<input type="checkbox"/>				
Cancer (list type)	<input type="checkbox"/>				
Other major disease(s) that run in family:					

EYE QUESTIONS

Are you interested in Laser Vision Correction to improve your vision? <input type="checkbox"/> Y <input type="checkbox"/> N <div style="text-align: right;"><input type="checkbox"/> Would like more information</div>	
Current form of vision correction: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses	
Eye Conditions/History: <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Dry Eye Syndrome <input type="checkbox"/> Uveitis <input type="checkbox"/> Lazy eye <input type="checkbox"/> Diabetic Eye Disease <input type="checkbox"/> Eye Injury Other – Please Write In:	
Current Eye Medications , including over-the-counter. <input type="checkbox"/> I take no eye medications	
Past Eye Surgeries, with dates:	

Have you ever smoked? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, Year of: Start: _____ Stop: _____ How many cigarettes/day now?	Do you drive? <input type="checkbox"/> Y <input type="checkbox"/> N
---	---

PLEASE FILL OUT BACK ALSO →

REVIEW OF SYSTEMS

Do you **currently** have problems in the following areas? If “YES,” please provide information.

	YES	NO	Explanation of Problem
GENERAL (Fatigue, weight loss, fever/chills, etc.)			
NEUROLOGICAL (dizziness, headache, loss of function, etc.)			
EAR, NOSE, THROAT (Sinusitis, dry mouth, etc.)			
CARDIOVASCULAR (heart trouble, circulatory problems, high blood pressure)			
RESPIRATORY (Asthma, etc.)			
GASTROINTESTINAL (Pain, diarrhea, etc.)			
GENITAL/KIDNEY/BLADDER (Frequency, pain, etc.)			
MUSCLES, BONES, JOINTS (arthritis, etc.)			
SKIN (rash, growths, cancer, etc.)			
PSYCHIATRIC (anxiety, depression, etc.)			
ENDOCRINE (heat or cold intolerance, diabetes, hyperthyroid, etc.)			
BLOOD (anemia, bruising, swelling, etc.)			
OB/GYN: (pregnancy, pain, discharge, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus flare-up, Sjogren’s, etc.)			