Lynn Eye Medical Group

2230 Lynn Road, Suite 102 • Thousand Oaks, CA 91360 • (805) 495-0458

Original Date _____Patient Initials_____
Reviewed Date_____ Patient Initials _____
Reviewed Date_____ Patient Initials_____
Reviewed Date_____ Patient Initials_____

Detailed Medical History Questionnaire

Name_____

Date of birth ____/____/_____

Date of your last eye exam _____/_____/_____ With whom? _____

List any medications you currently take (prescription and over-the-counter) _____

_____

Do you have allergies to any medications? No Yes If "yes," list the medications _____

_____

Are you allergic to latex? No Yes

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) and/or injuries (concussion, etc) _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____

_____

Do you currently have any problem in the following areas? If "yes," please provide details.

Condition	No	Yes	Details
Eyes			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eye; lazy eye			
Drooping eyelid			
General/Constitution: Fever, weight loss, other			
Ears/Nose/Throat: Stuffy nose, earache, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, racing pulse, etc.			
Respiratory: Congestion, wheezing, asthma, etc.			
Gastrointestinal: Upset stomach, diarrhea, constipation, etc.			
Genital/Kidney/Bladder: Painful urination, frequent urination, impotence, etc.			

- ***Please complete side 2*** -

Condition	No	Yes	Details
Muscles/Bones/Joints: Joint pain, stiffness, swelling, cramps, etc.			
Skin: Pimples, warts, growths, rash, etc.			
Neurological: Numbness, headache, etc.			
Psychiatric: Anxiety, depression, insomnia			
Endocrine: Diabetes, hypothyroid, etc.			
Blood/Lymph: Cholesterolemia, anemia, etc.			
Allergic/Immunologic: Sneezing, swelling, redness, itching, hives, etc.			
Women only: Are you pregnant?			

Family History							
Condition	No	Yes		Mother	Father	Sibling	Grand-parent
Blindness							
Glaucoma							
Arthritis							
Cancer							
Diabetes							
Heart disease or high blood pressure							
Kidney disease							
Lupus							
Stroke							
Thyroid disease							
Other:							

Social History:

Current occupation: _____

Education: Preschool Elementary High school College Other_____
Marital status: Married Divorced Widowed Single Child
Living arrangement: Own home With child(ren) Rental Retirement home Assisted living
Do you drive? No Yes
Do you have visual difficulty when driving? No Yes
Do you have problems with night vision? No Yes
Have you ever tried to wear contact lenses? No Yes
Do you currently wear contact lenses? No Yes If "yes," how long? _____
Do you currently wear glasses? No Yes If "yes," how old is your current prescription?
_____
Have you ever had a blood transfusion? No Yes
Do you drink alcohol? No Yes If "yes," Occasionally 1/day 2-3/day 4+/day
Do you smoke? No Yes If "yes," Occasionally ½ pk/day 1 pk/day 1+ pk/day

[#1] Roy T. Butera, M.D.
[#2] Devin C. Hymas, M.D.
[#3] Gene M. Matzkin, M.D.
[#4] Charles A. Cooper, M.D.
[#5] Joel M. Corwin, M.D.
[#6]John L. Davidson, M.D.
[#7] Daniel A. Ebroon, M.D.
[#8] Adam Martidis, M.D.
[#9] Jaspinder Kalra, O.D.
[#10] Wanda Hu, M.D.
[#11] Xiaolin Zhang, M.D.

Physician's signature: #_____ Date_____/_____/_____
Physician's signature: #_____ Date_____/_____/_____
Physician's signature: #_____ Date_____/_____/_____
Physician's signature: #_____ Date_____/_____/_____