Focal Point Vision Medical Questionnaire

Patient: **DOB:**

SOCIAL HISTORY- Please check all that apply

Alcohol Use:	Yes ☐ No ☐	Tobacco Use:	Yes ☐ No ☐	Able to read English	Yes ☐ No ☐	Drives vehicle motor	Yes ☐ No ☐

PAST OCULAR HISTORY-Please check all that apply

Cataracts	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Amblyopia (Lazy Eye)	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Retinal Detachment	Yes ☐ No ☐	Astigmatism	Yes ☐ No ☐
Diabetic Retinopathy	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐	Myopia (Near sighted)	Yes ☐ No ☐
Keratoconus	Yes ☐ No ☐	Floaters	Yes ☐ No ☐	Hyperopia (Far sighted)	
Floaters	Yes ☐ No ☐	Eye Infections	Yes ☐ No ☐	Any Other:_____	
Eye Injuries	Yes ☐ No ☐	Corneal Ulcers	Yes ☐ No ☐		

OCULAR SURGERIES/PROCEDURES-Please check all that apply

Cataract Surgery	Yes ☐ No ☐	Retinal Laser Surgery	Yes ☐ No ☐	Lasik/PRK/RK	Yes ☐ No ☐
Corneal Transplant	Yes ☐ No ☐	Glaucoma Surgery	Yes ☐ No ☐	Any Other: _____	Yes ☐ No ☐

FAMILY HISTORY- Please check all that apply

Blindness	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Fuch's Dystrophy	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Retinal Detachment	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐	Corneal Transplant	Yes ☐ No ☐

Please check if you *CURRENTLY HAVE OR HAD* any of the following

Arthritis/Joint problems	Yes ☐ No☐	Fever	Yes ☐ No☐	Prostrate Problems	Yes ☐ No☐
Asthma	Yes ☐ No☐	Gastritis/Reflux	Yes ☐ No☐	Psychiatric problems/Depression	Yes ☐ No☐
Bleeding Disorder	Yes ☐ No☐	Gout	Yes ☐ No☐	Sinus Problems/Allergies	Yes ☐ No☐
Bronchitis/COPD/ Emphysema	Yes ☐ No☐	Heart Disease/Attack	Yes ☐ No☐	Stroke or Neurological problems	Yes ☐ No☐
Chronic Headaches/ Migraines	Yes ☐ No☐	Herpes Simplex	Yes ☐ No☐	Thyroid Disease	Yes ☐ No☐
Chest Pain/Discomfort	Yes ☐ No☐	High Blood Pressure	Yes ☐ No☐	Tuberculosis	Yes ☐ No☐
Disabilities	Yes ☐ No☐	High Cholesterol	Yes ☐ No☐	Ulcers	Yes ☐ No☐
Diabetes Type: 1☐ 2 ☐ Insulin dependent? Yes ☐No ☐	Yes ☐ No☐	HIV	Yes ☐ No☐	Unexplained Weight loss/gain	Yes ☐ No☐
Dialysis	Yes ☐ No☐	Jaundice/Hepatitis	Yes ☐ No☐	Other:_____	Yes ☐ No☐
Excessive Bleeding with surgery	Yes ☐ No☐	Kidney /Renal Problem	Yes ☐ No☐		

Primary Care Physician: _____

Referring Eye Care Provider: _____

Form Completed by: _____ Relationship: _____

PATIENT SIGNATURE: _____ **DATE:**

REVISED 10-01-2015