DELANEY EYE CARE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ **First Name** _____ **MI** _____

Address _____ City _____ State _____ Zip _____

If patient is a minor: Grade? _____ Responsible Party _____

Work Phone (_____) _____ Home Phone (_____) _____

Cell Phone (_____) _____ Email _____

Date of Birth _____ Social Security Number _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Not Hispanic or Latino

Occupation _____ Employer _____

Emergency Contact _____ Phone (_____) _____

Date of last eye exam _____ Dilated? ☐ Yes ☐ No

Today's Date _____ Referred by _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these systems? (Please check Yes or No)

Gastrointestinal	☐ Yes ☐ No	Nervous	☐ Yes ☐ No	Endocrine (glands)	☐ Yes ☐ No
Ears/Nose Throat	☐ Yes ☐ No	Urinary	☐ Yes ☐ No	Blood/lymph	☐ Yes ☐ No
Cardiovascular	☐ Yes ☐ No	Muscles/bones	☐ Yes ☐ No	Allergic/immunologic	☐ Yes ☐ No
Respiratory	☐ Yes ☐ No	Integumentary (skin)	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Eyes	☐ Yes ☐ No	Mental	☐ Yes ☐ No

Please explain _____

Diabetes ☐ Yes ☐ No Type _____ Date of diagnosis _____

Tobacco use: ☐ Never smoked
☐ Current Smoker (how much _____ # years_____) ☐ Former Smoker (year quit_____ Smoker for # years_____)

Allergies to medication? ☐ Yes ☐ No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____ Check if none ☐

Have you had any operations? ☐ Yes ☐ No Kind: _____ When? _____

Name of family doctor _____

Date of last visit _____ Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure	☐ Yes ☐ No	Relation _____	Macular degeneration	☐ Yes ☐ No	Relation _____
Diabetes	☐ Yes ☐ No	Relation _____	Retinal detachment	☐ Yes ☐ No	Relation _____
Glaucoma	☐ Yes ☐ No	Relation _____	Cataracts	☐ Yes ☐ No	Relation _____

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? ☐ Yes ☐ No If yes, what kind? _____

Have you had any eye operations? ☐ Yes ☐ No Type _____ Date _____

Have you had an eye injury? ☐ Yes ☐ No Type _____ Date _____

Do you have glaucoma?	☐ Yes ☐ No	Cataracts?	☐ Yes ☐ No	Dry eyes?	☐ Yes ☐ No
Macular degeneration?	☐ Yes ☐ No	Retinal detachment?	☐ Yes ☐ No	Blurred vision?	☐ Yes ☐ No
Do you wear glasses?	☐ Yes ☐ No	Contact lenses?	☐ Yes ☐ No	Type _____	

Additional information _____

Name of person completing form _____ Signature _____

Relationship to patient _____ Date _____

DOCTOR USE ONLY

Reviewed by _____ ☐ No changes Date _____

Reviewed by _____ ☐ No changes Date _____

Reviewed by _____ ☐ No changes Date _____