**Gregory McCormick, MD** • Cataract, Cornea & Refractive Surgery
**Katherine Lane, MD** • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
**Robert McGlynn, MD** • Glaucoma & Cataract Surgery
**Thomas Cavin, MD, FACS** • Cataract Surgery
**Suzanne Corbitt, OD** • Primary Eye Care

# MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

Name of physician or person referring you: _____

## REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If "YES" give an explanation

| | | | EXPLANATION OF PROBLEM |
|---|---|---|---|
| Integument (skin) | YES | NO | _____ |
| Eyes | YES | NO | _____ |
| Ears, nose, mouth , throat | YES | NO | _____ |
| Breasts | YES | NO | _____ |
| Neck | YES | NO | _____ |
| Respiratory (lungs/breathing) | YES | NO | _____ |
| Cardiovascular (heart/high blood pressure) | YES | NO | _____ |
| Gastrointestinal (stomach/intestines) | YES | NO | _____ |
| Genitourinary (genitals/kidneys/bladder) | YES | NO | _____ |
| Bones, joints, muscles, and arthritis | YES | NO | _____ |
| Neurologic system (stroke) | YES | NO | _____ |
| Lymphatic (lymph nodes/swelling) | YES | NO | _____ |
| Hematopoietic (blood) | YES | NO | _____ |
| Cancer | YES | NO | _____ |
| Endocrine (diabetes/thyroid) | YES | NO | _____ |
| Allergic and immunologic | YES | NO | _____ |
| Psychiatric | YES | NO | _____ |

## PAST HISTORY

List any medications you take: _____

List all major illnesses and injuries you have had in the past: _____

List any surgeries you have had in the past: _____

List any hospitalizations with explanation of what they were for: _____

Do you have allergies to any medications? YES___ NO___ If YES, list medications: _____

Do you have any other allergies? _____

_____

**(PLEASE SEE OTHER SIDE)**

OPHTHALMIC CONSULTANTS OF VERMONT

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VERMONT LASER VISION AT TIMBER LANE

List current Immunization status: _____

**FAMILY HISTORY**

What is the health status of your parents, siblings or children? _____

_____

Any diseases in the family? Circle "YES" or "NO" below. If "YES", indicate the relationship to the patient.

| **DISEASES** | | | **RELATIONSHIP TO PATIENT** |
|---|---|---|---|
| Blindness | YES | NO | _____ |
| Cataracts | YES | NO | _____ |
| Glaucoma | YES | NO | _____ |
| Macular Degeneration | YES | NO | _____ |
| Retinal Detachment | YES | NO | _____ |
| Arthritis | YES | NO | _____ |
| Cancer | YES | NO | _____ |
| Diabetes | YES | NO | _____ |
| Heart Attacks | YES | NO | _____ |
| High Blood Pressure | YES | NO | _____ |
| Kidney Disease | YES | NO | _____ |
| Stroke | YES | NO | _____ |
| Thyroid Disease | YES | NO | _____ |
| Other | YES | NO | _____ |

**SOCIAL HISTORY (Please Circle):**

Marital Status: Single Married Divorced Widowed Other

**PRESENT OCCUPATION:** _____

What kind of work have you done in the past?:_____

Do you use street drugs? YES NO If "YES", please indicate what: _____

Do you drink alcohol? YES NO If "YES", how many glasses a day? _____

Do you smoke? YES NO If "YES", how many packs a day? _____

**EDUCATION LEVEL (PLEASE CIRCLE)**

High School graduate College graduate Post graduate degree Other

Have you ever had any of the following sexually transmitted diseases?:

Gonorrhea: YES____ NO____ AIDS: YES____ NO_____ HIV: YES ____ NO____ Syphilis: YES_____ NO_____

**PHARMACY INFORMATION**

What pharmacy do you use?: _____

**HISTORY REVIEW**

Physician Signature: Thomas J. Cavin, MD _____ Date: _____

Gregory J. McCormick, MD _____ Date: _____

Katherine A. Lane, MD _____ Date: _____

Robert H. McGlynn, MD _____ Date: _____

Suzanne Corbitt, OD _____ Date: _____