OPHTHALMIC CONSULTANTS OF VERMONT

Gregory McCormick, MD • Cataract, Cornea & Refractive Surgery
Katherine Lane, MD • Cosmetic, Oculofacial Plastic & Reconstructive Surgery
David Shiple, MD • Cataract, Cornea & Comprehensive Ophthalmology

VERMONT LASER VISION AT TIMBER LANE

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?

Integument (skin)	YES	NO
Eyes	YES	No
Ears, Nose, Mouth, Throat	YES	NO
Breasts	YES	NO
Neck	YES	NO
Respiratory (lungs)	YES	NO
Cardiovascular (heart/high blood pressure)	YES	NO
Gastrointestinal (stomach/intestines)	YES	NO
Genitourinary (genitals/kidneys/bladder)	YES	NO

Bones, Joints, Muscles, Arthritis	YES	NO
Neurological (stroke)	YES	NO
Lymphatic (lymph nodes/swelling)	YES	NO
Hematopoietic (blood)	YES	NO
Cancer	YES	NO
Endocrine (diabetes/thyroid)	YES	NO
Allergic & Immunologic	YES	NO
Psychiatric	YES	NO
Are you currently pregnant or breast feeding?	YES	NO

If yes to any of the above, please explain: _____

_____

_____

PAST MEDICAL HISTORY		
Arthritis	YES	NO
Collagen Vascular Disease	YES	No
Diabetes	YES	NO

Dry Eyes	YES	NO
Thyroid Disease	YES	No
Rheumatoid Arthritis	YES	NO
Skin Problems	YES	NO

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 the medications: _____

Do you have any other allergies? ☐ YES ☐ NO If YES, list the allergy: _____

Have you ever had unusually slow healing from a skin wound or injury or keloid scar? ☐ YES ☐ NO

List current Immunization status: _____

Have you ever had any of the following sexually transmitted diseases?
Gonorrhea: ☐ YES ☐ NO AIDS: ☐ YES ☐ NO HIV: ☐ YES ☐ NO Syphilis: ☐ YES ☐ NO

What pharmacy do you use (include the town): _____

(PLEASE SEE OTHER SIDE)

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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
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? _____		

PRESENT OCCUPATION: _____

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

EDUCATION LEVEL (PLEASE CIRCLE)

High School graduate College graduate Post graduate degree Other: _____

HISTORY REVIEW

Provider Signature:

Gregory J. McCormick, MD _____ Date: _____

Katherine A. Lane, MD _____ Date: _____

David A. Shiple, MD _____ Date: _____