Kenneth P. Adams, DO., PC.

Medical History Questionnaire

Kenneth P. Adams, DO., PC. *is committed to excellence in ophthalmology and appreciate you taking the time to complete this confidential registration form. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us we will be happy to help.*

Today's Date:_____

_____ _____

First Last Middle Initial Preferred Name

____/____/_____ _____ _____

Birth date Age SS#

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injures (concussion, etc.):_____

_____

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

_____

Do you have allergies to medications? [] YES [] NO If YES, list the medications and reactions: _____

Current Medications

Medication	Dosage	Frequency

Pediatric History (Fill out **ONLY** if patient is a child)

Birth weight :_____ lbs. _____ oz. [] Premature [] Full Term

Describe any problems during pregnancy, labor, delivery or after birth: _____

Is your child 's growth and development normal? [] YES [] NO If NO, please describe: _____

Child 's School: _____ Child 's Grade Level: _____ Performance: _____

Whom does your child live with most of the time?: _____

PLEASE LIST ALL SIBLINGS BELOW

NAME	AGE	HEALTH PROBLEMS (IF ANY)

Social History

Do you live alone?.....[] YES [] NO

Do you have transportation?.....[] YES [] NO

Do you drink alcohol?.....[] YES [] NO If YES, how often: occasional 1/day 2-3/day 4+/day

Do you smoke?.....[] YES [] NO If YES, how often: occasional 1/day 2-3/day 4+/day

	YES	NO		YES	NO		YES	NO		YES	NO
EYES			**EARS, NOSE, THROAT**			**GENITAL/KIDNEY/BLADDER**			**PHYCHIATRIC**		
Loss of vision			Stuffy nose			Painful urination			Anxiety		
Blurred vision			Runny nose			Frequent Urination			Depression		
Distorted vision			Ear ache			Impotence			Insomnia		
Double vision			Cough			**MUSCLES/BONES/JOINTS**			**ENDOCRINE**		
Floaters			Dry mouth			Joint Pain			Diabetes		
Light flashes			**CARDIOVASCULAR**			Stiffness			Hypothyroid		
Fluctuating vision			High blood pressure			Swelling			**BLOOD/LYMPH**		
Other vision changes			Racing Pulse			Cramps			High cholesterol		
Tearing			Palpitations			Bruising			Anemia		
Dry eyes			Chest Pain			**SKIN/NAILS**			**ALLERGIC/IMMUNOLOGIC**		
Light sensitivity			Pain in arm or jaw			Pimples			Sneezing		
Droopy eyelid			Extremity changes or pain			Warts			Swelling		
Redness			Lightheaded or fainting			Growths			Redness		
Drainage or discharge			**RESPIRATORY**			Rash			Itching		
Itching			Congestion			**NEUROLOGICAL**			Hives		
Pain and discomfort			Wheezing			Headache			**GENERAL/HORMONAL**		
Infection of eye or lid			**GASTROINTESTINAL**			Migraine			Fever		
Tired eyes			Stomach Ulcers			Numbness			Weight Loss		
Crossed eye, lazy eye			Intestinal Disease						Weight Gain		
Foreign body sensation			GERD								

Family History

M= Mother F= Father S= Sibling G= Grandparent

	RELATIVE		RELATIVE
[] YES [] NO AMBLYOPIA (LAZY EYE)		[] YES [] NO HIGH BLOOD PRESSURE	
[] YES [] NO CROSSED OR WANDERING EYE		[] YES [] NO CATARACTS IN CHILDHOOD	
[] YES [] NO PROBLEMS WITH ANESTHESIA		[] YES [] NO KIDNEY DISEASE	
[] YES [] NO ARTHRITIS		[] YES [] NO LUPUS	
[] YES [] NO BLINDNESS		[] YES [] NO PROBLEMS	
[] YES [] NO DIABETES		[] YES [] NO EARLY DEATH	
[] YES [] NO EYE CANCER		[] YES [] NO RETINAL PROBLEMS	
[] YES [] NO GLAUCOMA		[] YES [] NO STROKE	
[] YES [] NO GENETIC PROBLEMS		[] YES [] NO THYROID PROBLEMS	
[] YES [] NO HEART DISEASE		[] YES [] NO CANCER	

I have reviewed and/or updated the above information and confirm it as accurate.

Patient Signature _____ **Date** _____

OFFICE USE ONLY

Physician's Signature _____ Date _____

Kenneth P. Adams, DO