

**OPHTHALMOLOGY ASSOCIATES  
THE CORNEA AND LASER VISION INSTITUTE**

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**HEALTH QUESTIONNAIRE**

Name \_\_\_\_\_ Date \_\_\_\_\_

Correct answers to the following questions will allow our doctors to treat you on a more individual basis. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health in the past year ..... YES NO
2. My last physical examination was on \_\_\_\_\_
3. Are you now under the care of a physician ..... YES NO  
If so, what is the condition being treated \_\_\_\_\_
4. The name and address of my physician is \_\_\_\_\_
5. Have you had any serious illness within the past five (5) years ..... YES NO  
If so, what was the illness \_\_\_\_\_
6. Have you been hospitalized or had an operation within the past five (5) years ..... YES NO  
If so, what was the problem \_\_\_\_\_
7. Do you have or have you had any of the following diseases or problems
  - a. Rheumatic fever or rheumatic heart disease ..... YES NO
  - b. Congenital heart disease ..... YES NO
  - c. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high/low blood pressure, stroke, arteriosclerosis, etc. .... YES NO
    - 1) Do you have pain in chest upon exertion ..... YES NO
    - 2) Are you ever short of breath after mild exertion ..... YES NO
    - 3) Do your ankles swell ..... YES NO
    - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... YES NO
  - d. Artificial or replacement heart valves ..... YES NO
  - e. Pacemaker ..... YES NO
  - f. Allergy ..... YES NO
  - g. Sinus trouble ..... YES NO
  - h. Asthma or hay fever ..... YES NO
  - i. Hives or skin rash ..... YES NO
  - j. Fainting spells or seizures ..... YES NO
  - k. Diabetes ..... YES NO
    - 1) Do you have to urinate (pass water) more than six times per day ..... YES NO
    - 2) Are you thirsty much of the time ..... YES NO
    - 3) Does your mouth frequently become dry ..... YES NO
  - l. Hepatitis, jaundice or liver disease ..... YES NO
  - m. Arthritis or inflammatory rheumatism ..... YES NO
  - n. Artificial or replacement joints, prosthetic ..... YES NO
  - o. Digestive system-Ulcers or stomach disorders (colitis) ..... YES NO
  - p. Kidney trouble ..... YES NO
  - q. Tuberculosis ..... YES NO
  - r. Persistent cough or cough up blood ..... YES NO
  - s. Immune System Disorders (including AIDS, HIV, ARC) ..... YES NO

Please see reverse side of form for signature

- t. Venereal Disease ..... YES NO
- u. Other \_\_\_\_\_
8. My last eye examination was on \_\_\_\_\_
9. Do you have or have you had any of the following eye diseases or problems
- a. Glaucoma ..... YES NO
- b. Cataracts ..... YES NO
- c. Retina Detachment ..... YES NO
- d. Near Sightedness ..... YES NO
- e. Far Sightedness ..... YES NO
- f. Crossed Eyes (Strabismus) ..... YES NO
- g. Lazy eye (Amblyopia) ..... YES NO
10. Do you wear contact lenses ..... YES NO
- If so, what type and how long \_\_\_\_\_
11. Have you had abnormal bleeding associated with previous surgery or trauma ..... YES NO
- a. Do you bruise easily ..... YES NO
- b. Have you ever required a blood transfusion ..... YES NO
- If so, explain the circumstances & when \_\_\_\_\_
12. Have you ever tested positive for the AIDS virus ..... YES NO
13. Do you have any blood disorder such as anemia ..... YES NO
14. Have you had surgery or x-ray treatment for a tumor, growth or other condition ..... YES NO
15. Are you taking any of the following:
- a. Antibiotics ..... YES NO
- b. Anticoagulants (blood thinners) ..... YES NO
- c. Medicine for blood pressure ..... YES NO
- d. Cortisone (steroids) ..... YES NO
- e. Tranquilizers ..... YES NO
- f. Antihistamines ..... YES NO
- g. Aspirin ..... YES NO
- h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... YES NO
- i. Digitalis, Lanoxin or drugs for heart trouble ..... YES NO
- j. Nitroglycerin ..... YES NO
- k. Birth control pills ..... YES NO
- l. Other medications \_\_\_\_\_
- m. If "YES" to any of the above, state drug name, dosage and frequency \_\_\_\_\_
16. Are you allergic or have you reacted adversely to:
- a. Local anesthetics ..... YES NO
- b. Penicillin ..... YES NO
- c. Sulfa drugs ..... YES NO
- d. Barbituates, sedatives or sleeping pills ..... YES NO
- e. Aspirin ..... YES NO
- f. Iodine ..... YES NO
- g. Codeine or other narcotics ..... YES NO
- h. Other \_\_\_\_\_
17. Do you use any tobacco products ..... YES NO
- If so, how much per day/week and length of time \_\_\_\_\_
18. Do you use any alcohol products ..... YES NO
- If so, how much per day/week and length of time \_\_\_\_\_
19. Do you have any disease or condition not otherwise mentioned, if so, explain \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING INFORMATION IS CORRECT.

Patient, Parent or Guardian Signature \_\_\_\_\_