EYE CARE ASSOCIATES
26850 Providence Pkwy., Suite 150
Novi, MI 48374
248-380-8066

PATIENT HEALTH QUESTIONNAIRE

Patient's Name ____

Preferred Pharmacy: ______________________ Pharm. Phone: ________________

Do you now or have you ever had any of the following medical conditions?
(Please circle any that apply.)

Heart disease	Yes	No	Diabetes	Yes	No
Irregular heartbeat	Yes	No	High blood pressure	Yes	No
Breathing problems	Yes	No	Seizures	Yes	No
Blood clotting disorder	Yes	No	Glaucoma	Yes	No
Bleeding disorder	Yes	No	Lazy Eye	Yes	No
Stroke or TIA	Yes	No	Treatment for any eye disease	Yes	No
Current smoker	Yes	No			

Does anyone in your family now, or ever, have any of the following?

Diabetes	Yes	No	Glaucoma	Yes	No
High blood pressure	Yes	No	Heart disease	Yes	No
Macular degeneration	Yes	No			

Are there any other serious medical conditions that you are being treated for?

Please list all medications you are currently taking:

Please list all medication allergies, including any you reacted to in the past:

Date____________________ Signature ________________________________