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American Board of Ophthalmology

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

Answering the questions below, will supply needed information to make appropriate decisions to care for your eye problem or eye surgery. Use the reverse side of this page if more space is needed. Thank you.

LIST ALL CURRENT PRESCRIPTION MEDICATIONS (including eye drops and skin preparations).

NAME	Mg. Or cc. per unit	Amount taken	How Often?

WHAT MEDICINES ARE YOU ALLERGIC TO OR CANNOT TAKE? (For example: Aspirin, Tylenol, Penicillin, Codeine, Novocain, Xylocaine, Demerol, Morphine, Iodine, Bromide, Sulfites, etc.)

CHECK APPROPRIATE SPACES FOR THE MEDICINES OR SUBSTANCES USED:

YES

_____ Tobacco
_____ Alcohol
_____ Beer, Wine, Cocktails
_____ Anticoagulants
_____ Blood thinners
_____ Aspirin
_____ Persantine (dipyridamole)
_____ Cortinsone (prednisone etc.)
_____ Arthritis pills
_____ Naprosyn
_____ Motrin (Ibuprofen)
_____ Advil
_____ Tylenol
_____ Indocin
_____ Clinoril
_____ Feldene
_____ Cytec
_____ Nuprin
_____ Mediprin

YES

_____ Antidepressants:
_____ Elavil (amitriptyline)
_____ Desyrel
_____ Norpramine
_____ Pamelor
_____ Marplan
_____ Sinequan
_____ Tranquilizer
_____ name: _____
_____ Sleeping pill
_____ name: _____
_____ Diabetes Medicine
_____ Insulin
_____ Orinase
_____ Micronase
_____ Glucatrol
_____ Tolinase
_____ Other _____

Name of your Medical Doctor: _____

Address: _____

Phone #: _____ Fax #: _____

PATIENT'S SIGNATURE: _____ DATE: _____

PHARMACY INFORMATION: