

Patient Medical History Questionnaire

DATE _____

NAME _____ Acct# _____

Date of Birth _____ SEX M ___ F ___ Weight _____ Height _____ Race _____

REVIEW OF SYSTEMS:

CIRCLE YES OR NO ON ALL

Cardiovascular

Y N Heart disease
 If yes List _____
 Y N Heart attack-
 Date _____
 Y N Angina
 Date of last episode _____
 Y N Stroke
 Date _____
 Y N High bloodpressure
 Y N Pacemaker
 Defibrillator Y N
 (attach copy of card)
 Y N Elevated Cholesterol

Skin Problems

Y N Keloids/Scarring
 Y N Rosacea

Ear/Nose/Throat

Y N Hearing Loss
 Y N Wear hearing
 aids

Endocrine

Y N Diabetes
 Date of diagnosis _____
 ___ Diet-Controlled
 ___ Oral medication-
 Controlled
 ___ Insulin-Controlled
 ___ Insulin Pump

Y N Thyroid

Y N Gout

Respiratory

Y N Asthma
 Y N Emphyzema
 Y N COPD
 Y N Tuberculosis
 Y N Other Lung disease
 Type _____

Gastrointestinal

Y N Ulcers
 Y N Colitis
 Y N Diverticulitis
 Y N Liver/hepatitis
 Y N Crohn's disease
Genitourinary Problems
 Y N Kidney
 Y N Bladder
 Y N Prostate
 If yes, have you ever used
 Flomax _____

Hematologic

Y N Anemia
 Y N Bleed/bruise
 easily

Immunologic

Y N Herpes Zoster
 Y N Sarcoidosis
 Y N Sjogrens

Musculoskeletal

Y N Arthritis
 Y N Joint replacement
 Y N Lupus
 Y N Rheumatoid Arthritis
 Y N Fibromyalgia

Neurologic/Psychiatric

Y N Seizures/Convulsions
 Y N Alzheimer's
 Y N Dementia
 Y N Parkinson's disease
 Y N Bells Palsy
 Y N Migraine Headaches
 Y N Cancer
 Type _____
 Y N Other (please list)

All other systems negative ____

Past Medical History: (please list any surgery, injuries, operations or hospitalizations other than eyes)

Please list all MEDICATIONS that you are currently taking INCLUDING EYEDROPS & VITAMINS

Medication	Strength	How Often	Medication	Strength	How Often

Are you allergic to any medications? ___ Yes ___ No If yes, please list _____

Are you allergic to IODINE? Yes No

Are you allergic to LATEX? Yes No

***** OVER FOR ADDITIONAL QUESTIONS *****

EYE HISTORY:

Last Eye Exam: _____ How old are your glasses? _____

CIRCLE YES OR NO ON ALL

Have you ever been diagnosed with:

- | | | | |
|-----|----------------------|-----|----------------------|
| Y N | Cataracts | Y N | Macular degeneration |
| Y N | Glaucoma | Y N | Retinal disorders |
| Y N | Diabetic retinopathy | Y N | Corneal problems |

Eye Surgery/Eye Trauma: Please list:

Right Eye _____

Left Eye _____

SOCIAL HISTORY: (Check One)

- | | | |
|---------------------|------------------------------|----------------------|
| Alcohol use | Tobacco Use | |
| ___ None | ___ None | ___ Live alone |
| ___ Social use only | ___ Former | ___ Live with spouse |
| ___ 1-2 drink daily | ___ Less than 1 pack per day | ___ Live with family |
| ___ Above average | ___ More than 1 pack per day | |

FAMILY HISTORY:

CIRCLE YES OR NO ON ALL AND INDICATE RELATIONSHIP

- | | |
|--|----------------------------------|
| Y N Cancer _____ | Y N Hypertension _____ |
| Y N Heart disease _____ | Y N Retinal Disorders _____ |
| Y N Diabetes _____ | Y N Retinal Detachment _____ |
| Y N Glaucoma _____ | Y N Other Retinal Problems _____ |
| Y N Age-Related Macular Degeneration _____ | |

Other: (please list) _____

PRIMARY MEDICAL PHYSICIAN _____

CITY/STATE _____ **PHONE #** _____

CARDIOLOGIST _____

CITY/STATE _____ **PHONE #** _____

Have you ever taken **Flomax**? _____

If you take **blood-thinning** medication, when did you last have blood work? _____

If so, where? _____

Does your physician recommend antibiotics prior to surgery and/or dental work? ___Yes ___No

If yes, indicate type of antibiotic _____

If you have had a joint replacement (knee, hip, etc.), who was your surgeon?

Surgeon's Name _____

Address _____

Patient Signature _____