EYE CARE & SURGERY, PC

Medical History Questionaire

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any medications (and dosages) you currently take (Rx and over-the-counter):

FLU Shot: Y N

Pneumonia Vaccine: Y N

Do you have allergies to any medications? YES NO

If YES, list the medications:

List all major illness (diabetes, high blood pressure, heart, etc.) or major injuries (disability, inpatient, etc.)

List any surgeries you have had (gall bladder, appendectomy, etc.)

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
GENERAL / CONSTITUTIONAL (weight loss, weight gain, fever, unusually tired, etc.)			
EARS, NOSE, THROAT (decreased hearing, stuffy nose, earache, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (asthma, shortness of breath, congestion, etc.)			
GASTROINTESTINAL (acid reflux, diarrhea, ulcers, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination prostate problems, frequent urination, impotence, etc.)			
FEMALES (hysterectomy, breast cancer, pregnant **NOW**?, etc.)			
MUSCLES, BONES, JOINTS (arthritis, joint replacement, cramps, etc.)			
SKIN (cancers, growths, rashes, etc.)			
NEUROLOGICAL (headaches, seizures, paralysis, numbness, weakness, etc.)			
PSYCHIATRIC (anxiety, depression, memory, etc.)			
ENDOCRINE (diabetes, thyroid issues, etc.)			
CIRCULATORY (bleeding, anemia, high cholesterol, HIV, etc.)			
IMMUNOLOGIC (lupus, mixed-connective tissue disorders, etc.)			

FAMILY HISTORY: Has any member of your immediate family (mother, father, siblings) had these diseases (circle all that apply)

Glaucoma, Cataracts, Macular Degeneration

Diabetes, Hypertension, Heart Disease, Thyroid Disease, Cancer, Other heritable disease:

SOCIAL HISTORY

Do you drink alcohol?..... YES NO if YES, how much?

Do you smoke?.....YES NO if YES, how much? How many years?

Physician's Signature *Date*