

MEDICAL HISTORY QUESTIONNAIRE

Name _____

Birth Date _____

Referred by: _____ Family Doctor: _____

Current Medications List Supplied

Food or Drug Allergies List Supplied

Do you now have or have you recently had any of the following:

- Light Sensitivity
- Redness
- Flashing Lights
- Floaters
- Itchiness
- Trouble Focusing
- Pain
- Double Vision
- Distorted Vision
- Decreased Vision
- Dryness
- Discharge
- Glare
- Tobacco Use
- Alcohol Use
- Wear Contacts
- Previous Corneal Surgery
- Flomax Use

HEALTH CONDITIONS

NONE
Explain / Comments

- Allergies _____
- Angina _____
- Anxiety / Depression _____
- Arthritis _____
- Asthma _____
- Atrial fibrillation _____
- Blood clots _____
- Cancer _____
- Cardiac arrhythmia _____
- COPD _____
- Coronary artery disease _____
- Diabetes
Type I x _____ yrs
Type II x _____ yrs
- High Cholesterol _____
- GERD _____
- Headache _____
- Heart disease _____
- Hepatitis/liver disease _____
- HIV + or AIDS _____
- Hypertension _____
- Irritable bowel disease _____
- Myocardial infarction _____
- Renal disease _____
- Seizure disorder _____
- Stroke _____
- Thyroid disease _____
- Other: _____

SURGICAL

NONE

- Cardiac CABG / Pacemaker / Stent _____
- Cholecystectomy _____
- Gastric bypass _____
- Hip replacement RT LT _____
- Knee replacement RT LT _____
- Back surgery _____
- Other _____

Year

FAMILY HISTORY:

NONE ADOPTED

S/B= Sister or Brother, **M=** Mother, **F=** Father

List How Related

- Amblyopia _____
- Arthritis _____
- Asthma _____
- Blindness _____
- Cancer _____
- Cardiovascular disease _____
- Diabetes _____
- Glaucoma _____
- High Cholesterol _____
- Hypertension _____
- Macular degeneration _____
- Migraines _____
- Seizure disorder _____
- Stroke _____
- Thyroid disorder _____
- Other: _____

I affirm the information I provided regarding my medical and patient information to be complete and accurate.
 I understand and agree regardless of insurance status, I am responsible for the balance on this account for any professional services rendered.
 I acknowledge that I have been provided access to Henry Eye Clinic's Notice of Privacy Policies.

Patient Signature _____

Physician's Signature _____ Date _____

