Henry Eye Clinic

Date _____

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

Year

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

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 _____