Henry Eye Clinic

Date ___________________

MEDICAL HISTORY QUESTIONNAIRE

Name ____ Birth Date ________________________

Referred by: ______________________________ Family Doctor: ___________________________________

Current Medications ☐ **List Supplied**

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Food or Drug Allergies ☐ **List Supplied**

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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: ______________________

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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 __________________