Patient Information/ Medical History Questionnaire Date_____

Name _____ Birth Date _____ ☐ M ☐ F Occupation_____
Address _____ City _____ State _____ Zip Code_____
Phone ( )_____ Alt. Phone ( )_____ Email _____

Do you now, or have you ever had, a history/surgery of the following:

If you check YES, please circle/describe the condition.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

	Yes	No	Describe here
Significant Weight Loss, Current Fever(Constitution)			
Ears, Nose, Mouth, Throat, Allergies			
Heart, High Blood Pressure, stroke (Cardiovascular)			
Asthma, emphysema, Tuberculosis (Respiratory)			
Bladder, STD, kidney, prostate (Genitourinary)			
Arthritis, osteoporosis (Musculoskeletal)			
Skin disease/disorder- Psoriasis, Eczema(Integument)			
Epilepsy, Seizures, Headaches/Migraine (Neurologic)			
Depression, anxiety, dementia (Psychiatric)			
Diabetes, Thyroid, Hypoglycemia (Endocrine Disor)			
Anemia, High cholesterol, Liver Dis (Blood/Lymph)			
Lupus, HIV, Herpes, Multiple scleros (Immunologic)			
Irritable bowel, Crohn's Ds, colitis, ulcers (Digestive)			
Cancer/Currently Pregnant/other medical problems			

SIGNIFICANT IMMEDIATE FAMILY HISTORY

	Yes	No	If yes, state who
Diabetes			
High Blood Pressure/Stroke/Heart problems			
Glaucoma			
Retinal Disease, Macular Degeneration			
Cancer			
Other			

EYE HISTORY

	Yes	No	Specify Left or Right Eye
Injuries, Prosthesis			
Surgery, Laser treatment			
Lazy Eye (Amblyopia, Exotropia, Esotropia)			
Double Vision (prism)			
Corneal (Dry eye, scar, Keratoconus, Fuch's)			
Cataracts			
Glaucoma			
Retina, Vitreous/Floaters			
Macular Degeneration			
Loss of vision			

Current Medications:

Current Eye Meds:

Allergic to any Medications? List:

SOCIAL HISTORY

	Y	N
Tobacco		
Alcohol		
Recreational drugs		

Last Eye Exam _____
Dr._____
Eye(s) Dilated ☐Y ☐N
Primary Care Physician:
Dr._____

Insurance Information

Insurance_____ Insured Name_____ Ins. Birth Date_____
Insured's Employer_____ ☐Full time ☐Part time ☐Retired
Relationship to Insured: ☐Self ☐Spouse ☐Dependent Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced
Patient's ID#_____ Group#_____

Thank you!