1630 Adams Street
Mankato, MN 56001
507-345-6151/Fax 507-625-1096

Emily Birkholz, M.D.
Seth Consoer, M.D.
John Hoines, M.D.
Gerald Roust, M.D.
Justin Kuiper, M.D.
Nathan Carpenter, M.D.

MEDICAL HISTORY QUESTIONAIRE

TODAY'S DATE: ________________________

NAME: _____________________________________ DATE OF BIRTH: _________________

ADDRESS: ____
(STREET, CITY, STATE, ZIP)

PHONE: ________________________ SOCIAL SECURITY #: _________________________

CELL: __________________________ EMAIL: ______________________________________

EMPLOYER: ___________________________________ PHONE: ______________________

Race: __________________________ Preferred Language: _____________________________

ALLERGIES: ____

CURRENT MEDICATIONS: ____

____

EMERGENCY CONTACT: ____

RELATIONSHIP: ______________________________ PHONE: ____________________

I, _______________________________________, have read or received a copy of the Privacy Policy For Ophthalmology Associates & Lasik Center.

___________________________ ________________________________
Patient Signature **Date Signed**

Are you **currently** experiencing any of the following symptoms?

☐ Fatigue ☐ Sore throat ☐ Cough
☐ Chest pressure / discomfort ☐ Abdominal pain
☐ Headache ☐ Back pain

PAST MEDICAL HISTORY / REVIEW OF SYSTEM

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer – type: ____________________
☐ Chronic Cough
☐ Depression
☐ Hepatitis – type (A, B, C): _____
☐ HIV Positive
☐ High Blood Pressure
☐ Lupus / Sjogrens Syndrome
☐ Pacemaker
☐ Peripheral Vascular Disease
☐ Prostate Disease

(OVER)

Continued – PAST MEDICAL HISTORY / REVIEW OF SYSTEM

☐ Diabetes ☐ Type 1 ☐ Type 2
☐ Excessive Thirst / Urination
☐ Heart Attack
☐ Heart Condition – type: ______________________
☐ Heart Surgery – type: ________________________
☐ Rheumatoid Arthritis
☐ Shortness of Breath
☐ Stomach Ulcers
☐ Stroke
☐ Thyroid Disease

FAMILY HISTORY – Has any blood relative ever had the following:

Disease	Yes	No	Relationship to Patient
Cataract	☐	☐	________________________________
Diabetes	☐	☐	________________________________
Glaucoma	☐	☐	________________________________
Macular Degeneration	☐	☐	________________________________
Retinal Detachment	☐	☐	________________________________

List previous eye injuries, eye surgeries, or eye diseases (Macular Degeneration, Cataracts,

LASIK, etc.): ____

____

____

SOCIAL HISTORY

Do you use tobacco? ☐ Currently ☐ Formerly ☐ Never ☐ Unknown
Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Other

Amount per day: ______________________ Years used: _____________________________

Have you ever tried to quit? ☐ No ☐ Yes Year Quit: ______________________

Longest tobacco free: ______________ Relapse reason: __________________________________

Are you passively exposed to smoke? ☐ No ☐ Yes

Smoker status:
☐ Current every day smoker ☐ Smoker, current status unknown ☐ Former smoker

☐ Current some day smoker ☐ Never smoker ☐ Unknown if ever smoked