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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
☐ Blood In Urine
☐ Hepatitis – type (A, B, C): _____
☐ HIV Positive
☐ High Blood Pressure
☐ Lupus / Sjogrens Syndrome
☐ Pacemaker
☐ Peripheral Vascular Disease
☐ Prostate Disease
☐ Hives

(OVER)

Continued – PAST MEDICAL HISTORY / REVIEW OF SYSTEM

☐ Seasonal Allergies
☐ 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