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**MEDICAL HISTORY QUESTIONNAIRE**

TODAY'S DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_

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:

<b><u>Disease</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>	<b><u>Relationship to Patient</u></b>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____

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