Taustine Eye Center

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date_____

Name of physician referring you _____ Physician Phone _____

Physician Address _____

Primary Medical Doctor (if different from above) _____

PAST HISTORY

What Eye medications do you use? _____

What Eye Surgeries have you had? _____

Do you currently wear glasses? _____ When was your last eye examination? _____

List any medications you take:_____

_____

_____

Please list any medications you are **ALLERGIC** to: _____

_____

_____

Please list any major illnesses and injuries: _____

_____

_____

Please list any surgeries you have had: _____

_____ _____

FAMILY HISTORY

Do any of your relatives have these problems?

DISEASE	YES	NO	Relationship to you
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal detachment	☐	☐	_____
Diabetes	☐	☐	_____
Heart Attacks	☐	☐	_____
High Blood Pressure	☐	☐	_____

SOCIAL HISTORY

Current occupation: _____

Do you drink alcohol? ☐ YES ☐ NO If YES, how many glasses a day? _____

Do you smoke? ☐ YES ☐ NO If YES, how many a packs? _____

Please answer the questions on the next page

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

	YES	NO	EXPLANATION OF PROBLEM
Ears, nose, mouth, throat	☐	☐	_____
Cardiovascular (heart/blood vessels)	☐	☐	_____
Respiratory (lungs/breathing)	☐	☐	_____
Gastrointestinal (stomach/intestines)	☐	☐	_____
Musculoskeletal (bones, joints, muscles)	☐	☐	_____
Skin (rashes, lumps, bumps, redness, etc.)	☐	☐	_____
Neurological (numbness, paralysis, etc.)	☐	☐	_____
Psychiatric (anxiety, depression, etc.)	☐	☐	_____
Endocrine (diabetes, thyroid etc.)	☐	☐	_____
Hematologic/Lymphatic (anemia, etc.)	☐	☐	_____
Allergic/Immunologic (AIDS, allergies)	☐	☐	_____

FOR PHYSICIAN USE ONLY

☐ History Reviewed ☐ No Changes ☐ Additions as noted above

PHYSICIAN'S SIGNATURE _____

DATE

☐ History Reviewed ☐ No Changes ☐ Additions as noted above

PHYSICIAN'S SIGNATURE _____

DATE

☐ History Reviewed ☐ No Changes ☐ Additions as noted above

PHYSICIAN'S SIGNATURE _____

DATE

☐ History Reviewed ☐ No Changes ☐ Additions as noted above

PHYSICIAN'S SIGNATURE _____

DATE

☐ History Reviewed ☐ No Changes ☐ Additions as noted above

PHYSICIAN'S SIGNATURE _____

DATE