Print Clear

Arizona Eye SPECIALISTS

MEDICAL HISTORY QUESTIONNAIRE

Date_____

Name _____ Date of Birth _____ Male ◯ Female ◯

Primary Care Doctor_____ Referring Doctor (if different) _____

Pharmacy_____ Date of last eye exam _____

List any medications you currently take (Rx and/or over the counter): None ◯ See Attached List ◯ Daily Aspirin ◯

MEDICATIONS	MG	#OF TIMES/ DAY

Height_____ Weight_____

DO YOU USE:

Tobacco: No ◯ Yes ◯

How Much_____

Alcohol: No ◯ Yes ◯

How Often _____

Recreation Drugs No ◯ Yes ◯

Do you wear Contact Lenses? No ◯ Yes ◯ What Brand _____

Do you use Eye Drops/Ointment?No ◯ Yes ◯ Explain_____

Do you have any allergies to any medications or substances? YES ◯ NO ◯

If YES, list the medications or substances and your reaction:

_____

_____

_____

Reaction to Anesthesia? No ◯ Yes ◯

Explain_____

_____

Have you ever had an allergic reaction or any sensitivity to latex? NO ◯ YES ◯ Explain _____

List any surgeries you have had in the last 10 years (appendectomy, hysterectomy, gallbladder removal, etc.) and the year(s) they were performed:

SURGERY	YEAR	SURGERY	YEAR

Have any members of your family been diagnosed with any eye disease? NONE Diabetic Eye Disease Glaucoma Cataract

Macular Degeneration Retinal Detachment Crossed Eyes Blindness Serious Eye Injury Other _____

Have you ever been diagnosed with any eye disease? NONE Diabetic Eye Disease Cataract Glaucoma Lazy Eye

Macular Degeneration Retinal Detachment Iritis Crossed Eyes Blindness Serious Eye Injury

List any EYE SURGERIES or EYE INJURIES you have had and the year(s) they were performed. NONE

Type of Surgery	EYE	Year	Physicians Notes
_____	R L	_____	_____
_____	R L	_____	_____
_____	R L	_____	_____

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HEALTH HISTORY

Do you currently have any problems in the following areas? **If YES, please provide additional information.**

DISEASE	YES	NO	ADDITIONAL INFORMATION
GENERAL/CONSTITUTIONAL (Fever, heat stroke, weight loss, weight gain, fatigue)	☐	☐	
EAR, NOSE, THROAT (Hard of hearing, ear infection, sinus, chronic cough, dry mouth)	☐	☐	
CARDIOVASCULAR (High blood pressure, racing pulse, heart attack, heart disease, stroke, etc.)	☐	☐	
RESPIRATORY (Asthma, emphysema, COPD, shortness of breath, prolonged cough, wheezing, sputum production, etc.)	☐	☐	
GASTROINTESTINAL (Stomach ulcers, diarrhea, hernia, constipation, GERD, etc.)	☐	☐	
GENITIAL, KIDNEY, BLADDER (Painful or frequent urination, dialysis, impotence, jaundice, etc.)	☐	☐	
MUSCLES, BONES, JOINTS (Arthritis, Sjogren's, joint pain, muscle aches, joint swelling, back pain, etc.)	☐	☐	
SKIN (Acne, cancer, psoriasis, eczema, etc.)	☐	☐	
NEUROLOGICAL (Bell's palsy, frequent headaches, double vision, weakness, difficulty walking, loss of balance, MS, tremors, dizziness, sleep apnea, loss of consciousness, seizures, etc.)	☐	☐	
PSYCHIATRIC (Anxiety, depression, hallucinations, memory loss, dementia, Alzheimer's, etc.)	☐	☐	
ENDOCRINE (Diabetes, thyroid disease, high cholesterol, etc.)	☐	☐	
BLOOD/LYMPH (Aids/HIV, anemia, leukemia, unexplained swelling or bruising, etc.)	☐	☐	
ALLERGIC/IMMUNOLOGIC (Seasonal allergies, hay fever symptoms, itching, frequent infections, Lupus, etc.)	☐	☐	
INFECTIOUS DISEASE (Hepatitis, herpes, tuberculosis,)	☐	☐	
OB/GYNECOLOGIC (Are you pregnant?)	☐	☐	
CANCER	☐	☐	

PATIENT NAME (please print) _____

_____ _____

Patient Signature Date

OFFICE USE

Received by _____ Date_____