Atlantic Eye, LLC

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____
DATE OF BIRTH: _____ **DATE OF LAST EYE EXAM:** _____ **ACCOUNT#** _____
List any **medications** you currently take (Rx and over-the-counter): _____
_____
_____
Do you have **allergies** to any medications: YES NO
If *YES*, list the medications: _____
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.)
_____
List any **surgeries** you have had (cataract, LASIK, appendectomy): _____
_____

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

	YES	NO	Details
EYES (poor vision, pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES – Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swellings, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusions, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? **YES NO UNKNOWN**
Blindess, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease: _____

SOCIAL HISTORY

	YES	NO	
Does your vision limit any activities of daily living? (driving, reading, sports, work, etc.)			
Have you ever had a blood transfusion?			
Do you drink alcohol?			If *YES*, how much?
Do you smoke?			If *YES*, how much? How many yrs?

Physician's Signature _____ ***Date:*** _____