Concord Eye Center
MEDICAL HISTORY QUESTIONNAIRE

Name____________________________________ Date_____________________________

Date of **Birth**
Primary Care Doctor ______________________________
Occupation ______________________________

Date of last eye exam ___________________
Referring Doctor ________________________

List any **medications** you currently take (Rx and over-the-counter). Include dosage and frequency: ____________

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Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:____

Have you ever had a **Pneumonia Vaccine**? **YES NO**

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):
____

List any **surgeries** you have had (cataract, appendectomy): ______________________________
____

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

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, 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, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (**diabetes**, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, 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**

Macular Degeneration, Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis **Other Heritable Disease:**_____________________________________

SOCIAL HISTORY

Do you drink alcohol?...........**YES** **NO** If YES, how much? ___________
Do you smoke? ....**YES** **NO** If YES, how much? ___________ How many years? ____________

Are you interested in learning more about cosmetic services and products we offer? ____Yes ___No

Patient's Signature ______________________________________ Date ______________________
Physician's Signature ______________________________________ *Date* ______________________

Rev 4/15