

EYE CENTERS OF FLORIDA

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date _____

NAME _____ MINOR Y ___ N ___

Acct# _____

Date of Birth _____ SEX M ___ F ___ Weight _____ Height _____ Race _____

PLEASE CIRCLE YES NO

Cardiovascular

- Y N Heart Disease
- Y N Heart Attack
Date: _____
- Y N Angina
(date of last episode)
- Y N Mitral Valve Prolapse

Endocrine

- Y N Diabetes
- Y N Thyroid

Gastrointestinal

- Y N Ulcers
- Y N Colitis
- Y N Diverticulitis
- Y N Liver/hepatitis

Musculoskeletal

- Y N Arthritis
- Y N Joint replacement
- Surgeon: _____
- City, State: _____

- Y N Artificial Heart Valve
- Y N Stroke
Date: _____
- Y N High Blood Pressure
- Y N Pacemaker
(attach copy of card)

Skin Problems

- Y N Scarring
- Y N Keloids

Ear/Nose/Throat

- Y N Hearing Loss
- Y N Hearing aids

Respiratory

- Y N Lung Disease
- Y N Tuberculosis
- Y N Chest

Genitourinary Problems

- Y N Kidney
- Y N Bladder
- Y N Prostate

Hematologic

- Y N Anemia
- Y N Bleed/bruise
easily

Neurologic/Psychiatric

- Y N Seizures/
Convulsions
- Y N Parkinson's
Disease
- Y N Cancer
- Y N Alzheimer's
- Y N Other(please list)

Past Medical History: (please list any surgery, injuries, operations or hospitalizations other than eyes)

Please list all MEDICATIONS you are currently taking INCLUDING EYEDROPS & VITAMINS

Medication	Strength	How Often	Office Use Only	Medication	Strength	How Often	Office Use Only

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NAME _____

Are you allergic to any medications? ___Yes ___No If yes, please list medications and reactions:

Are you allergic to IODINE? ___Yes ___No

Eye History: Have you ever been diagnosed with:

- | | |
|-----------------------|--------------------------|
| Y N Cataracts | Y N Macular Degeneration |
| Y N Glaucoma | Y N Diabetic Retinopathy |
| Y N Retinal Disorders | Y N Corneal problems |

Eye Surgery/ Eye Trauma: Please list

Right Eye _____

Left Eye _____

Social History: Smoking : Y N Alcohol: Y N Occupation/ Hobbies _____
Live Alone _____ Live with spouse _____ Live with family _____

Family history:

- | | | |
|-----------------------|--------------|--------------------------|
| Y N Cancer | Y N Diabetes | Y N Hypertension |
| Y N Heart Disease | Y N Glaucoma | Y N Macular Degeneration |
| Y N Retinal Disorders | | |

Does your physician recommend antibiotics prior to surgery and or dental work? Yes No

If yes, indicate type of antibiotic _____

Primary Medical Physician _____ City _____ State ___ Phone # _____

Cardiologist _____ City _____ State ___ Phone # _____

Patient Signature _____

Reviewed by: _____/_____ **Date:** _____

UPDATES:

Reviewed by: _____/_____ Date: _____ [] Updated [] No change

Reviewed by: _____/_____ Date: _____ [] Updated [] No change

Reviewed by: _____/_____ Date: _____ [] Updated [] No change

Reviewed by: _____/_____ Date: _____ [] Updated [] No change

Reviewed by: _____/_____ Date: _____ [] Updated [] No change

Reviewed by: _____/_____ Date: _____ [] Updated [] No change