Eye Centers of Florida

PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ MR # _____________________ Date: _____________

Date of Birth: ________________ Age:____ ☐ Male ☐ Female Weight: ________ Height:_______

Past Ocular History: (Please mark all that apply)

- ☐ **Amblyopia (Lazy eye)**
- ☐ **Cataract Surgery**
- ☐ **Astigmatism**
- ☐ **Cataracts**
- ☐ **Diabetic Retinopathy**
- ☐ **Dry Eyes**
- ☐ **Glaucoma**
- ☐ **Hyperopia (Far sighted)**
- ☐ **Iritis**
- ☐ **Keratoconus**
- ☐ **Macular Degeneration**
- ☐ **Myopia (Near sighted)**
- ☐ **Optic Neuritis**
- ☐ **Retinal Detachment**

Ocular Surgeries: (Please mark all that apply)

- ☐ **No prior ocular surgery**
- ☐ **Retinal Laser Surgery**
- ☐ **Strabismus Surgery**
- ☐ **Foreign Body Removal**
- ☐ **RK Glaucoma Surgery**
- ☐ **Corneal Transplant**
- ☐ **Blepharoplasty (Lid Surgery)**
- ☐ **LASIK (Refractive Surgery)**
- ☐ **PRK (Refractive Surgery)**
- ☐ **Punctal Plugs**
- ☐ **Cataract Surgery**

FAMILY HISTORY:

- ☐ **Cancer**
- ☐ **Hypertension**
- ☐ **Diabetes**
- ☐ **Macular Degeneration**
- ☐ **Glaucoma**
- ☐ **Blindness**
- ☐ **Heart Disease**

☐ **Flu VacDate:________**
☐ **PneumVac Date:_____**

DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

Circle Y or N & What Applies	**Circle Y or N & What Applies**	**Circle Y or N & What Applies**	
Y N Arthritis / Lupus	**Y N** High Cholesterol	**Y N** Ears/nose/throat (dry mouth)	
Y N Cancer	**Y N** Skin – lesions, moles	**Y N** General: i.e., fever / weight loss	
Y N Diabetes	**Y N** Insomnia	**Y N** Migraines / memory problems	
Y N Heart Attack **Y N** Pacemaker/Defibrillator	**Y N** Anxiety / Depression	**Y N** Muscle joints i.e. joint swelling/prednisone **Y N** Steroid use	
Y N Heart Disease/ Murmur/Irregular Heartbeat	**Y N** Liver Disease	**Y N** Lymph	
Y N High Blood Pressure	**Y N** Thyroid Disease	**Y N** Blood Thinners /Aspirin/Plavix/Coumadin/Xarelto	
Y N Shortness of breath	**Y N** Bladder Problems	**Y N** Blood i.e. anemia / bleeding problems	
Y N Asthma / Emphysema	**Y N** Sleep Apnea	**Y N** Dementia/ Alzheimers	
Y N Kidney Disease /Stones	**Y N** Fibromyalgia	**EYES**	
Y N Stroke / TIA (mini Stroke)	**Y N** Hepatitis **A B C**	**Y N Previous Surgery**	**Y N Flashes**
Y N HIV / AIDS	**Y N** Herpes	**Y N Contact Lenses**	**Y N Floaters**
Y N Bleeding Problems	**Y N** Vertigo/Dizzy	**Y N Redness**	**Y N Tearing**
Y N Acid Reflux	**Y N** Epilepsy /Seizures	**Y N Pain**	**Y N Dry Eyes**
Y N Crohn's Disease	**Y N** Tremors	**Y N Double Vision**	**Y N Implanted Contact Lens**
Y N Colitis	**Y N** Parkinson's		

Are you allergic to any medications (including iodine)? ☐ **Yes** ☐ **No** **If Yes, please list medications and reactions**

____

____

Are you allergic to Latex? ☐ Yes ☐ No If yes, please list reaction: ____________________

History of surgical procedures (including surgery or laser treatment on your eyes) ☐ Yes ☐ No (*If yes, please list all surgeries and dates)*______________________________________

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Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often? ____________________________

Drug Use: ☐ Yes ☐ No If yes, what and how often? ________________________________

Primary Care Physician: ______________________________ Phone #: ________________

Pharmacy: ____________________ Location: ____________________ Phone #: ______________

☐ ***Reviewed by Physician***

EYE CENTERS OF FLORIDA **PATIENT MEDICAL HISTORY QUESTIONNAIRE**

NAME ____________________________________ **Acct#**__________________ **Date** _______________________

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

Medication	Strength	How Often	Route	Medication	Strength	How Often	Route

Signature (Patient/Parent/Guardian/Conservator):________________________________ **Date** __________________

If other than patient, please indicate relationship: _________________________________

Office Use Only

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

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Reviewed by: ____________________/____________________ Date: _________________ [ ] Updated [ ] No change

Eye Centers of Florida

SURGICARE CENTER

Patient Label: ____ **Date:** ____________________

Patient Name:____ **MR:**____________________

DOB: _____________________________

The State of Florida requests that medical providers document patient race and ethnicity for purposes of data collection. Eye Centers of Florida reports this information to the State of Florida on a quarterly basis. The State of Florida reviews the collected information to insure that all residents in the state are receiving appropriate, quality care and that all geographic areas are equally served by medical providers.

The information will not be shared with anyone but the persons who have a right to know and the State of Florida. If you are comfortable providing the information requested, please complete the questions below.

If you chose not to provide the information please check the appropriate box, please check here and sign below:

☐ I choose not to provide this information

Thank you for assisting us in collecting this important information.

Ethnicity:

☐ Hispanic or Latino

☐ Non-Hispanic / Non - Latino

☐ Unknown

Patient Race:

☐ American Indian

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other

☐ Unknown

____

Signature of Patient