MEDICAL HISTORY QUESTIONNAIRE

Please bring this completed form to your appointment. Thank you.

Name:_____ Date:_____

Date of birth:_____

REFERRED BY: _____

PRIMARY CARE DOCTOR:_____

Clinic Name/Location:_____

Phone:_____ Fax:_____

Please explain the reason(s) for making this appointment today:_____

_____

_____

List any **MEDICATIONS** you currently take (prescription and over-the-counter): *if more space is needed, please attach a list*

Name:	**Strength (ie: mg) and Method of Administration (ie: tablet, capsule, injection, etc.)**

Do you have any **BLEEDING TENDENCIES** or take any **BLOOD THINNERS** (includes Aspirin, Coumadin, Plavix, Vioxx, Vitamin E, Herbal remedies, Advil, Ibuprofen, Naproxen, or similar products)?_____

_____

Do you have **ALLERGIES** to any medications? YES_____ NO_____

If YES, please list the medications and reaction type (including latex or iodine):_____

_____

List all **MAJOR ILLNESSES** or injuries (glaucoma, diabetes, high blood pressure, cancer, heart attack, etc.):_____

_____

_____

List any **SURGERIES** you have had (cataract, tonsillectomy, appendectomy, etc.):_____

_____

Do you drink **ALCOHOL?** YES_____ If YES, how often?_____ NO_____

Do you **SMOKE?** YES_____ If NO, please specify: QUIT:_____ NEVER_____

Have you worn contact lenses? YES_____ How long? _____ NO_____

OVER

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

	YES	NO	Please specify
GENERAL (Fever, Weight loss, etc.)			
SKIN (Sensitivities, poor healing, cancer, diseases, etc.)			
EAR, NOSE, THROAT (Sinus, cough, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTINAL (Reflux, Ulcer, etc.)			
GENITAL, KIDNEY, BLADDER (Incontinence, etc.)			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
NEUROLOGICAL (Multiple sclerosis, Migraines, etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia, etc.)			
ENDOCRINE (Diabetes, Thyroid, etc.)			
BLOOD, LYMPH (Anemia, Bleeding tendency, etc.)			
ALLERGIC, IMMUNOLOGIC (Hay fever, Sjogrens, etc.)			

FAMILY HISTORY

DISEASE	YES	NO	Relationship to Patient	Please specify illness
Heart disease, High blood pressure				
Lung disease				
Kidney disease				
Cancer				
Diabetes				
Thyroid disease				
Stroke				
Adverse anesthetic reaction				
Other				

SOCIAL HISTORY
Current occupation:
Education (High school, college degree, vocational, etc.):
Marital Status (Single, married, divorced, widowed):
Living arrangement (Live alone, assisted living, etc.):

May we use email to communicate *specials on cosmetic treatments or procedures* offered by our practice that we think may be of interest to you? E-mail address: _____

For Casey Eye Institute office use only

Physician's Signature: _____

Date history reviewed: _____