

David E. Palozej Eyecare Associates, LLC
Medical History Questionnaire

Please fill out all information to the best of your ability!

We apologize for this inconvenience, but due to changes in computer systems and insurance company requirements, we cannot efficiently care for you without this data.

Name: _____ Today's Date: ____/____/____

Address: _____ Home Phone: _____

City _____ State _____ Zip Code _____ Work / Cell Phone: _____

Birth Date: ____/____/____ Social Security #: ____-____-____ Employer: _____

Medical History Name of Medical Doctor: _____ Last Medical Exam: ____/____/____

Your Doctor's phone #: _____ Your Doctor's office is located in what town? _____

Are you PREGNANT or Nursing? Yes No

Do you have ALLERGIES to medications? Yes No If yes, list: _____

List any medications you take (including oral contraceptives, aspirin, over the counter and/or home remedies):

List all major injuries, surgeries, and/or hospitalizations you have had: _____

Personal Eye History Circle any of the following that you have had: Eye Injury Eye Surgery Cataract
Glaucoma Macular Degeneration Retinal Disease Crossed Eyes Lazy Eye Drooping Eyelid
Other: _____

Family History (parents, grandparents, siblings, children; living or deceased)

DISEASE/CONDITIONS

Relationship To You

| | | | |
|----------------------------|-----|----|-------|
| Blindness | Yes | No | _____ |
| Cataract | Yes | No | _____ |
| Crossed Eyes | Yes | No | _____ |
| Glaucoma | Yes | No | _____ |
| Macular Degeneration | Yes | No | _____ |
| Retinal Detachment/Disease | Yes | No | _____ |
| Arthritis | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Heart Disease | Yes | No | _____ |
| Thyroid Disease | Yes | No | _____ |
| Other | Yes | No | _____ |

****Please Turn This Form Over And Complete Side Two****

Social History This information is kept strictly confidential. However, if you would prefer to speak directly to the Doctor, circle YES. Otherwise, please answer the following questions:

Do you use tobacco products? Yes No If yes, type/amount/for how long: _____

Do you drink alcohol? Yes No If yes, type/amount/for how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/for how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Yes No ??

Review of Systems Have you ever been **SEEN BY A DOCTOR** for any of the following conditions??

Constitutional

Fever, Weight Loss / Gain Yes No ??

Integumentary (Skin) Yes No ??

Neurological

Headaches Yes No ??

Migraines Yes No ??

Seizures Yes No ??

Eyes

Loss of Vision Yes No ??

Loss of Side Vision Yes No ??

Distorted Vision / Halos Yes No ??

Double Vision Yes No ??

Itching / Burning Yes No ??

Sandy or Gritty Feeling Yes No ??

Foreign Body Sensation Yes No ??

Eye Pain or Soreness Yes No ??

Excess Tearing / Watering Yes No ??

Glare / Light Sensitivity Yes No ??

Tired Eyes Yes No ??

Mucous Discharge Yes No ??

Flashes / Floaters in Vision Yes No ??

Stye or Chalazion Yes No ??

Endocrine

Thyroid / Other Glands Yes No ??

Psychiatric Yes No ??

Allergic / Immunologic Yes No ??

Ear, Nose, Mouth, Throat

Allergies / Hay Fever Yes No ??

Sinus Congestion Yes No ??

Runny Nose Yes No ??

Post-Nasal Drip Yes No ??

Chronic Cough Yes No ??

Dry Throat / Mouth Yes No ??

Respiratory

Asthma Yes No ??

Chronic Bronchitis Yes No ??

Emphysema Yes No ??

Vascular / Cardiovascular

Diabetes Yes No ??

Heart Attack/Pain Yes No ??

High Blood Pressure Yes No ??

Vascular Disease Yes No ??

Gastrointestinal

Diarrhea/ Constipation Yes No ??

Genitourinary

Genitals / Kidney / Bladder Yes No ??

Bones / Joints / Muscles

Muscle/Joint Pain Yes No ??

Rheumatoid Arthritis Yes No ??

Lymphatic / Hematologic

Bleeding Problems Yes No ??

Anemia Yes No ??

If you answered YES to any of the above or have a condition not listed, please explain: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also know that this information will be held in the strictest confidence and that it is MY responsibility to inform this office of any changes. I authorize the doctor's optometric staff to perform any optometric service with my informed consent.

Patient's Signature _____ Date ___ / ___ / ___ Doctor's Signature _____ Date ___ / ___ / ___

Patient's Signature _____ Date ___ / ___ / ___ Doctor's Signature _____ Date ___ / ___ / ___

Patient's Signature _____ Date ___ / ___ / ___ Doctor's Signature _____ Date ___ / ___ / ___