Biloxi • Fairhope • Foley • Gulf Breeze • Mobile • Pensacola • Saraland • Spanish Fort •South Foley

Salmedina Alic, OD | Donna Corder, MD | Ayesha Kidd, OD | Paul McDaniel, DO | Hong Nguyen, OD | Courtney Ray, MD
Ray Rojas, MD | Gayla Rowland, MD | Dan Wilder, OD | Taylor Wolkart, OD | Peter Zloty, MD

Medical History Questionnaire

Patient Name: ______________________ **Sex:** ☐ Male ☐ Female **Date of Birth:** ______________

Address: ______________________________________ **Phone:** ______________

If this is your first visit, please complete.

Date of Last Eye Exam: ______________ Location: ______________________________

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other: ______________

Primary Care Doctor: ______________________________

Pharmacy: ______________________ **Location:** ______________________

Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Rapaflo ☐ Uroxatra ☐ Minipress ☐ Cardura ☐ Hytrin ☐ Avodart

Current Medications: ______________________________

____

Allergies to Medications: ______________________________

Check if you have ever had any of the following eye procedures: ☐ LASIK ☐ PRK ☐ RK ☐ Cataract Surgery ☐ Other ______________

List all current and previous illnesses, injuries, and surgeries: ______________________________

____

Please check any of the conditions you have today:

Cardiovascular:	☐ Chest Pain	☐ High Blood Pressure	☐ Irregular/Rapid Heartbeat	☐ N/A	
General:	☐ Fever	☐ Fatigue	☐ Shortness of Breath	☐ N/A	
Ears/Nose/Throat:	☐ Earache	☐ Nasal Congestion	☐ Pain	☐ N/A	
Gastrointestinal:	☐ Reflux	☐ Diarrhea	☐ Irregular/Rapid Heartbeat	☐ N/A	
Genitourinary:	☐ Trouble Urinating	☐ Discharge	☐ Ulcer	☐ N/A	
Integumentary:	☐ Skin Cancer	☐ Acne	☐ Rosacea	☐ Eczema	☐ N/A
Musculoskeletal:	☐ Arthritis	☐ Gout	☐ Joint or Muscle Pain	☐ N/A	
Neurological:	☐ Numbness	☐ Memory Loss	☐ Dizziness	☐ Stroke	☐ N/A
Psychiatric:	☐ Anxiety	☐ Depression	☐ N/A		
Endocrine:	☐ Diabetes	☐ Hypothyroidism	☐ Grave's Disease	☐ N/A	
Hematologic:	☐ Anemia	☐ High Cholesterol	☐ Bleeding Disorder	☐ N/A	
Immunologic:	☐ Allergies	☐ Immune Disorders	☐ HIV/AIDS	☐ Hep C	☐ N/A

Other: ______________________________

Please check if you or your blood relatives have any of the following conditions:

Blindness: ☐ Yes ☐ No ☐ Self ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Glaucoma: ☐ Yes ☐ No ☐ Self ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Macular Degeneration: ☐ Yes ☐ No ☐ Self ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Diabetes: ☐ Yes ☐ No ☐ Self ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Retinal Detachment: ☐ Yes ☐ No ☐ Self ☐ Father ☐ Mother ☐ Sibling ☐ Grandparent

Social History:

Do you currently smoke? ☐ Yes ☐ No **How much?** ☐ Less than 1 pack a day ☐ 1 pack a day ☐ More than 1 pack a day

Have you ever smoked? ☐ Yes ☐ No **When did you quit?** ______ **Are you pregnant?** ☐ Yes ☐ No **Anticipated due date?** ______________

Do you currently drive? ☐ Yes ☐ No **Are you working?** ☐ Yes ☐ No ☐ Retired

______________________________ ______________

Physician Signature **Date**