SOUTHERN EYE GROUP

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**