MEDICAL HISTORY QUESTIONNAIRE # Central Valley Eye Medical Group, Inc

Name: _____ Date of Birth: _____ Age: _____ Date:_____

Height:____ Weight: _____ Sex: Male / Female Primary Care Physician: _____

CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**NONE**
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon , other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all <u>OTHER</u> surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			**Family Member**	**Disease/Condition**			**Family Member**
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			Mother Father Sibling Grandparent

Physician Signature: _____ **Date:** _____

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

MEDICAL HISTORY QUESTIONNAIRE **Central Valley Eye Medical Group, Inc**

Patient Name:________________________________**Date of Birth:**______________**Date:**_____________

FAMILY MEDICAL HISTORY CONTINUED:

Is mother deceased? Y / N If yes- cause of death?________________________ Age at death?_______

Is father deceased? Y / N If yes- cause of death?________________________ Age at death?_______

SOCIAL HISTORY:

(Circle:) Student Homemaker Employed Retired **(Circle:)** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day ______# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ____________

Substance Abuse? Yes / No Rarely Daily Weekly ______________________________________

LIST ANY DRUG ALLERGIES: ____

____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

REVIEWED:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
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		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

Staff	*Date*

Physician Signature: ____

Date: _______________

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