

Emerald Coast Eye Institute, P.A.

Medical History Questionnaire

Name: _____ Date: _____

Please complete the following medical history questionnaire. Place a check in front of each problem if it applies to you.

General Health:

- fever
- >15 lbs. weight loss or gain in 6 months

Eyes:

- decreased vision
- light flashes
- glaucoma
- cataracts
- retinal problems
- eye surgery _____
- other _____
- floaters
- double vision
- macular degeneration
- diabetic eye disease
- headache

Ears/Nose/Throat:

- cancer
- hearing loss
- sinus disease
- other _____

Lungs:

- COPD, asthma
- other _____
- cancer

Heart:

- hypertension
- irregular beat
- other _____
- heart attack, when: _____
- congestive failure

Stomach/Colon:

- reflux
- cancer
- other _____
- ulcers
- hepatitis

**Kidney/Prostate/
Bladder/Genitals:**

- cancer
- venereal disease
- other _____
- kidney stones
- prostate enlargement

Endocrine:

- diabetes
- other _____
- thyroid

Neurologic:

- stroke
- cancer
- head injury
- other _____

Psychiatric:

- dementia
- psychosis
- depression
- other _____

Please turn page over to complete form

Musculoskeletal:	<input type="checkbox"/> cancer	<input type="checkbox"/> arthritis
	<input type="checkbox"/> joint pain/swelling	<input type="checkbox"/> other _____
Skin/Breast:	<input type="checkbox"/> skin cancer	<input type="checkbox"/> rash
	<input type="checkbox"/> breast cancer	<input type="checkbox"/> other _____
Blood/Lymphatics:	<input type="checkbox"/> anemia	<input type="checkbox"/> leukemia
	<input type="checkbox"/> lymphoma	<input type="checkbox"/> bleeding disorder
	<input type="checkbox"/> other _____	
Immune System:	<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS
	<input type="checkbox"/> low white cell count	<input type="checkbox"/> other _____
Rheumatologic:	<input type="checkbox"/> lupus	<input type="checkbox"/> rheumatoid arthritis
	<input type="checkbox"/> sarcoidosis	<input type="checkbox"/> other _____

Drug Allergies: _____

Other Allergies: _____ Latex Allergy Yes No

Current Medications: _____

Family History: check any of the following conditions that affect your blood relatives

<input type="checkbox"/> diabetes	<input type="checkbox"/> glaucoma	<input type="checkbox"/> cataracts
<input type="checkbox"/> macular degeneration	<input type="checkbox"/> blindness	<input type="checkbox"/> crossed eyes
<input type="checkbox"/> cancer, type _____		<input type="checkbox"/> other _____

Social History: check any category that applies to you now or in the past

<input type="checkbox"/> tobacco use, packs per day _____	<input type="checkbox"/> alcohol use
<input type="checkbox"/> recreational drug use	<input type="checkbox"/> sexually transmitted disease

Primary Medical Physician: _____

Primary Eyecare Provider: _____

Thank you for your help in completing this medical history form. This information will allow us to provide you with the most complete medical and surgical eyecare.