FRANCIS EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____
(Print) (Last) (First) (Middle) (MM/DD/YYYY)

Gender: ☐Male ☐Female Birthdate: _____ Primary Care Physician: _____
(MM/DD/YYYY)

Doctor Who Referred the Patient: _____ Reason for Visit: _____

Other Physicians (specify): _____

MEDICAL CONDITIONS

Has the patient ever been diagnosed with any of the following?

EYES:		**EXPLANATION**
Glaucoma	☐YES ☐NO	_____
Cataract	☐YES ☐NO	_____
Lazy Eye	☐YES ☐NO	_____
Crossed Eyes (Strabismus)	☐YES ☐NO	_____
Macular Degeneration	☐YES ☐NO	_____
Retinal Detachment	☐YES ☐NO	_____
Eye Injury	☐YES ☐NO	_____
Eye Inflammation	☐YES ☐NO	_____
Laser Surgery	☐YES ☐NO	_____
Operative Surgery	☐YES ☐NO	_____
GENERAL HEALTH:		
Asthma	☐YES ☐NO	_____
Bleeding Disorder	☐YES ☐NO	_____
Cancer (If yes, Type/When)	☐YES ☐NO	_____
Diabetes	☐YES ☐NO	_____
Environmental Allergies	☐YES ☐NO	_____
Gastroesophageal Reflux	☐YES ☐NO	_____
Hearing Loss	☐YES ☐NO	_____
Heart Disease	☐YES ☐NO	_____
Hepatitis (A,B, or C)	☐YES ☐NO	_____
High Blood Pressure	☐YES ☐NO	_____
High Cholesterol or Lipids	☐YES ☐NO	_____
HIV	☐YES ☐NO	_____
Kidney Disease	☐YES ☐NO	_____
Liver Disease	☐YES ☐NO	_____
Lung Disease	☐YES ☐NO	_____
Psychiatric Illness	☐YES ☐NO	_____
Stomach Ulcers	☐YES ☐NO	_____
Stroke	☐YES ☐NO	_____
Thyroid Disease	☐YES ☐NO	_____
Tuberculosis	☐YES ☐NO	_____

MEDICAL CONDITIONS

List any other medical illness: _____

_____

List any past surgeries or hospitalizations (please include year): _____

_____

Are you allergic to any medications/dyes? (If yes, list drug allergies and how you reacted.) _____

_____

_____

List current medications (i.e., over the counter medications, herbs, vitamins, aspirin, Coumadin, etc.): ☐See Attached List

☐List continued on back _____

_____

Are you pregnant? _____

SOCIAL HISTORY

		How Much/Often?
Alcohol Usage	☐YES ☐NO	_____
Cigarette Smoking	☐YES ☐NO	_____
Chewing Tobacco	☐YES ☐NO	_____
Exposure to Second Hand Smoke	☐YES ☐NO	_____
Do you Live Alone?	☐YES ☐NO	_____
Do you drive?	☐YES ☐NO	_____

Occupation: _____

FAMILY HEALTH HISTORY

Glaucoma	☐YES ☐NO	Cataract	☐YES ☐NO
Lazy Eye	☐YES ☐NO	Crossed Eyes (Strabismus)	☐YES ☐NO
Macular Degeneration	☐YES ☐NO	Retinal Detachment	☐YES ☐NO
Asthma	☐YES ☐NO	Hearing Loss	☐YES ☐NO
Bleeding Disorder	☐YES ☐NO	Heart Disease	☐YES ☐NO
Cancer	☐YES ☐NO	High Blood Pressure	☐YES ☐NO
Diabetes	☐YES ☐NO	Stroke/Seizure	☐YES ☐NO
Environmental Allergies	☐YES ☐NO	Family History Unknown	☐

Other Family Health History: _____

_____

Patient Name: _____ **MRN:** _____