Eye Surgery Associates

Date: _____

Patient Account Number: _____

Patient Medical History Questionnaire

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____ Alternate Phone Number: _____

Social Security Number: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: _____

Chief Complaint

What is the main thing that is bothering you regarding your eyes? _____

_____

History of Present Illness

How long have you had this problem? _____

Is it getting better, getting worse, or staying the same? _____

What treatments have you tried for this problem? _____

_____

What other eye disease or surgery have you had? _____

_____

Past Medical History

List diseases for which you are currently being treated or for which you have been treated in the past:

_____

List surgical procedures that you have undergone: _____

_____

Current Medications:

_____

_____

List all allergies to medications: _____

_____

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Review of Systems:

Please check **Yes** or **No** in the circles. If yes, check off any symptoms you are experiencing.

Constitutional Symptoms: YES ◯ NO ◯

_____ Fever
_____ Weight Loss
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Eye Problems: YES ◯ NO ◯

_____ Blurry Vision
_____ Burning of eyes
_____ Distorted vision
_____ Double vision
_____ Dryness
_____ Excess tearing/watering
_____ Foreign body sensation
_____ Glare/light sensitivity
_____ Itching of eyes
_____ Loss of side vision
_____ Mucous discharge from eyes
_____ Pain or soreness of eyes
_____ Redness of eyes
_____ Sandy or gritty feeling of eyes
_____ Stye

Difficulty:
_____ Reading small print
_____ Reading road signs
_____ Recognizing faces
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____
_____
_____
_____

Ear, Nose, Throat Problems: YES ◯ NO ◯

_____ Ringing in the ears
_____ Running ears
_____ Deafness
_____ Balance difficulties
_____ Nosebleeds
_____ Running nose
_____ Frequent sore throats
_____ Hoarseness of voice
_____ Difficulty swallowing
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____
_____
_____
_____

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Dental Problems: YES NO

_____ Loose teeth
_____ Bleeding gums
_____ Sore tongue
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Heart Problems: YES NO

_____ Chest pain on exertion
_____ Rapid heartbeat
_____ Irregular heartbeat
_____ Inability to lie flat
_____ Pounding sensation of heart
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Blood Vessel Problems: YES NO

_____ Pain in legs when walking
_____ Cold stiff hands
_____ Blackout spells
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Respiratory Problems: YES NO

_____ Wheezing
_____ Coughing up blood
_____ Shortness of breath
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Gastrointestinal Problems: YES NO

_____ Jaundice
_____ Stomach Pain
_____ Constipation
_____ Black stools
_____ Frequent diarrhea
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Genitourinary Problems YES NO

_____ Pain on urination
_____ Trouble holding your urine
_____ Blood in urine
_____ Frequent urination
_____ Pregnant now
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

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Skin or Breast Problems: YES ◯ NO ◯

_____ Rashes that do not go away
_____ New growth on skin
_____ Blood or mild discharge from nipple
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Musculo-Skeletal Problems YES ◯ NO ◯

_____ Joint swelling
_____ Joint pain
_____ Inability to make certain movement
_____ Muscle weakness
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Neurological Problems: YES ◯ NO ◯

_____ Fainting
_____ Dizziness
_____ Frequent headaches
_____ Convulsions or seizures
_____ Paralysis of any body part
_____ Numbness
_____ Blackout spells
_____ Loss of memory
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Psychiatric Problems: YES ◯ NO ◯

_____ Depression
_____ Mood Swings
_____ Panic attacks
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

Blood or Lymphatic Problems: YES ◯ NO ◯

_____ Easy bruising
_____ Excess bleeding from minor cuts
_____ Lumps in groin, armpit, or neck
_____ Other (specify)

Explanation of Problem:
(If no, proceed to next topic)
_____
_____
_____

FOR PHYSICIAN USE ONLY

Reviewed with patient: ☐

_____
Signed

_____
Date

Recommendations: