East Michigan Eye Center

PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ Acct#: _____ Date: _____

Date of Birth: _____ Age: ____ Race: _____ Ethncity: _____ M: ____ F: ____

PLEASE CHECK BOX IF THE ANSWER IS YES TO ITEMS BELOW:

☐ Cataracts ☐ Retinal Disorders ☐ Macular Degeneration
☐ Glaucoma ☐ Diabetic Retinopathy ☐ Corneal problems

FAMILY HISTORY:

☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Heart Disorders
☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Disorders

PLEASE CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS:

☐ **Cardiovascular**
- ☐ Heart Attack
- ☐ Angina
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator

Other: _____

☐ **Neurologic/Psychiatric**
- ☐ Seizures/Convulsion
- ☐ Parkinson's Disease
- ☐ Alzheimer's

Other: _____

☐ **Endocrine**
- ☐ Diabetes
- ☐ Thyroid

Other: _____

☐ **Hematologic**
- ☐ Anemia
- ☐ Bleed/bruise easily

Other: _____

☐ **Musculoskeletal**
- ☐ Arthritis
- ☐ Joint replacement

Other: _____

☐ **Stomach/intestinal**
- ☐ Ulcers
- ☐ Colitis

Other: _____

☐ **Respiratory**
- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis

Other: _____

☐ **Cancer** _____

☐ **Skin/Problems** _____

☐ **Ear/Nose/Throat** _____

☐ **Ocular Surface Disease**
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Watery eyes
- ☐ Swollen eyes
- ☐ Dry Eye
- ☐ Foreign Body Sensation

☐ **Additional Allergy Symptoms**
- ☐ Asthma
- ☐ Congestion
- ☐ Runny nose
- ☐ Dark circles under eyes
- ☐ Itchy/flaky skin

Are you allergic to any medications (including Iodine)? __ Yes __ No. If yes, please list medications and reactions: _____

_____

Eye Surgery/Trauma: Please List: Right eye _____ **Left eye** _____

Surgeries/hospitalizations within the last 5 years: _____

_____

Current List of Medications (including over-the-counter):

Name/Dosage	**Name/Dosage**	**Name/Dosage**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History: Smoking Quit Smoking—Year ____ Alcohol Use_____ Occupation_____

Primary Medical Physician: _____ **City** _____**ST** ___ **Phone:** _____