



Medical History Questionnaire

Last Name:		First Name:		DOB: / /	
Marital Status: S M D W		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security #: - - -	
Address:		City:		State: Zip Code:	
Home Phone:		Cell Phone:		Work Phone:	
Primary Care Physician:			Referring Dr:		
Main Pharmacy Name:					
Street Name & City:					
Phone:			Fax:		
List Of Allergies		Include Reaction		Severity	
				mild/moderate/severe	
				mild/moderate/severe	
				mild/moderate/severe	
				mild/moderate/severe	

Past Ocular History: (Please mark all that apply) _____ No history of eye problems

<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Iritis	<input type="checkbox"/> Optic Neuritis	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Floater	<input type="checkbox"/> Eye Trauma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Lazy Eye
Other:			

Ocular Surgeries: (Please circle Right, Left and all that apply) _____ No prior Ocular Surgery

R - L Foreign Body Removal	R - L Punctal Plugs	R - L Laser	R - L Cataract Surgery
R - L Blepharoplasty	R - L Retinal Laser Surgery	R - L RK	R - L LASIK
R - L Strabismus Surgery	R - L Vitrectomy	R - L Corneal Transplant	R - L PRK

Medical History (please check below): _____ No history of illnesses

<input type="checkbox"/> Thyroid Disease Hoshimotos/ Hypo / Hyper	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Headache	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lupus
<input type="checkbox"/> Arthritis Osteo / Rheumatoid	<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraine
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Insulin IDDM <input type="checkbox"/> NIDDM	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Polymyalgia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes Zoster/Shingles	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Toxoplasmosis
<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> Histoplasmosis	<input type="checkbox"/> MRSA	<input type="checkbox"/> Syphilis

Review of Systems: (Please check all that apply)

Eyes	Respiratory	Blood/Lymph nodes
() Previous Surgery	() Cough	() Easy Bruising
() Contact Lens	() Congestion	() Gums Bleed Easy
() Pain	() Wheezing	() Prolonged Bleeding
() Double Vision	() Asthma	() Heavy Aspirin Use
() Glaucoma		
() Cataracts		Musculoskeletal
() Macular Degeneration	Gastrointestinal	() Stiffness
() Dry Eyes	() Heartburn	() Arthritis
() Flashes	() Nausea / Vomiting	() Joint Pain / Swelling
() Floaters	() Jaundice / Hepatitis	
		Skin
Ear, Nose & Throat	Genito - Urinary	() Rash / Sores
() Hard of Hearing	() Pain / Difficulty	() Lesions
() Ringing in Ears	() Blood in Urine	() Hives / Eczema
() Vertigo	() History of Kidney Stones	
	() History of STD's	
Cardiovascular		Neurological
() Chest Pain	Psychiatric	() Seizures
() Dizziness	() Anxiety / Depression	() Weakness / Paralysis
() Fainting Spells	() Mood Swings	() Numbness
() Shortness of Breath	() Difficulty Sleeping	() Tremors
() Irregular Heart Beat		
() Difficulty Lying Flat	Endocrine	Immunologic
	() Increased Thirst	() Hives
Constitutional	() Increased Hunger	() Itching
() Fatigue / Weakness	() Increased Urination	() Runny Nose
() Fever	() Increased Sweating	() Sinus Pressure
() Weight Gain / Loss	() Fingernail Changes	

General Surgeries / Operations: (Please list)

Family History

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blindness	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> TB
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/>
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Retinal Disease	
Other:			

Social History: (Please check all that apply)

Smoking: current every day smoker current some day smoker
 former smoker never smoked

Alcohol Use: Yes No If yes, how much and how often? _____

Drug Use: Yes No If yes, what and how often? _____

Emergency Contact Information:

1. _____ Relationship: _____ Phone: _____
 2. _____ Relationship: _____ Phone: _____

Employment: Full Time Part Time Self-Employed Retired Not Employed Student

Name of Employer: _____ Phone: _____

I acknowledge that ALL information provided is true as I know it. I further acknowledge that the agreement made is between my insurance company and myself NOT Somerset Ophthalmology. I understand that Somerset Ophthalmology will bill my insurance on my behalf. Any services NOT covered under my insurance plan including deductibles and co-pays are my responsibility.

 Patient / Guardian Signature

 Date