FRANK EYE CENTER
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MEDICAL QUESTIONNAIRE

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ MARITIAL STATUS: M S W

BY WHAT NAME WOULD YOU WISH TO BE CALLED? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ REFERRED BY?

_____

WHAT IS YOUR PREFERRED PHARMACY? _____ ADDRESS? _____

WHAT IS YOUR PREFERRED METHOD OF CONTACT? EMAIL TEXT PHONE MAIL

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST THEM. _____

LIST ANY EYE DROPS YOU ARE CURRENTLY TAKING AND HOW OFTEN

_____

_____

LIST ANY MEDICATIONS, VITAMINS, HERBS OR PATCHES YOU CURRENTLY TAKE, INCLUDING THE STRENGTH:

_____

_____

_____

LIST ALL MAJOR ILLNESSES (GLAUCOMA, DIABETES, HIGH BLOOD PRESSURE, HEART ATTACK, ETC.) OR INJURIES (CONCUSSION, ETC.):

_____

_____

LIST ANY SURGERIES WITH APPROXIMATE DATES (i.e. CATARACT, APPENDECTOMY):

_____

_____

FAMILY HISTORY (**M**other, **F**ather, **G**randparent, **S**ibling) Have any members of your family had these diseases?

DISEASE	FAMILY MEMBER	DISEASE	FAMILY MEMBER
Blindness		Stroke	
Cataract		Heart Disease	
Glaucoma		Thyroid Disease	
Diabetes		Cancer	
Hypertension		Other:	

Would you like to be able to access your medical record through a secure on-line portal? Yes No

 NAME: _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION.

REVIEW OF SYSTEMS	YES	NO	DETAILS
CARDIOVASCULAR (chest pain, irregular heartbeat, shortness of breath, etc.)			
GENERAL/CONSTITUTIONAL (fatigue, fever, night sweats, weight loss, weight gain)			
ALLERGY (chronic runny nose, hives, itching, lupus, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, urgency, genital discharge, etc.)			Have you ever taken Flomax?
BLOOD PRESSURE CONTROL (good, poor, borderline, unknown)			
EARS, NOSE, THROAT (hearing loss, sore throat, dizziness)			
HEMATOLOGIC (bleeding, high cholesterol, anemia, bruising, etc.)			
METABOLIC (cold intolerance, heat intolerance, excessive thirst, etc.)			
MUSCLES, BONES, JOINTS (back pain, joint pain, muscle aches, stiffness, swelling)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
NEUROLOGICAL (balance problems, headache, numbness, seizures, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
RESPIRATORY (cough, trouble breathing, wheezing, asthma, COPD, etc.)			
SKIN (hair loss, rash, warts, growths, etc.)			
TUBERCULOSIS (positive TB test? Exposed to TB in past? Medicated for TB?)			
FEMALES are you pregnant? Nursing?			

SOCIAL HISTORY

What is your occupation? _____ Hobbies: _____

Does your vision limit any activities of daily living (driving, reading, sports, work, computer, etc.)?
YES NO List activities: _____

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____ How many years? _____

Are you a former smoker? _____ How many years? _____