Miramar Eye Specialists Medical Group

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New Patient Medical History Questionnaire

Name________________________________ Date of birth ____________ Today's date ___________

Date of your last eye exam _______________ With whom? ____________________________________

List any medications you currently take (prescription and over-the-counter) ________________________

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Do you have allergies to any medications? No Yes If "yes," list the medications _______________

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List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) and/or injuries (concussion, etc) ____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____________________

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Do you currently have any problem in the following areas? If "yes," please provide details.			
Condition	**No**	**Yes**	**Details**
Eyes			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eye; lazy eye			
Drooping eyelid			
General/Constitution: Fever, weight loss, other			
Ears/Nose/Throat: Stuffy nose, earache, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, racing pulse, etc.			
Respiratory: Congestion, wheezing, asthma, etc.			
Gastrointestinal: Upset stomach, diarrhea, constipation, etc.			
Genital/Kidney/Bladder: Painful urination, frequent urination, impotence, etc.			

- ***Please complete side 2*** -

Condition	No	Yes	Details
Muscles/Bones/Joints: Joint pain, stiffness, swelling, cramps, etc.			
Skin: Pimples, warts, growths, rash, etc.			
Neurological: Numbness, headache, etc.			
Psychiatric: Anxiety, depression, insomnia			
Endocrine: Diabetes, hypothyroid, etc.			
Blood/Lymph: Cholesterolemia, anemia, etc.			
Allergic/Immunologic: Sneezing, swelling, redness, itching, hives, etc.			

Family History

Condition	No	Yes		Mother	Father	Sibling	Grand-parent
Blindness							
Glaucoma							
Arthritis							
Cancer							
Diabetes							
Heart disease or high blood pressure							
Kidney disease							
Lupus							
Stroke							
Thyroid disease							
Other:							

Social History:

Current occupation: ______________________________

Education: Preschool Elementary High school College Other______________

Marital status: Married Divorced Widowed Single Child

Living arrangement: Own home With child(ren) Retirement home Assisted living

Do you drive? No Yes

Do you have visual difficulty when driving? No Yes

Do you have problems with night vision? No Yes

Have you ever tried to wear contact lenses? No Yes

Do you currently wear contact lenses? No Yes If “yes,” how long? ______________

Do you currently wear glasses? No Yes If “yes,” how old is your current prescription? ______________________

Have you ever had a blood transfusion? No Yes

Do you drink alcohol? No Yes If “yes,” Occasionally 1/day 2-3/day 4+/day

Do you smoke? No Yes If “yes,” Occasionally ½ pk/day 1 pk/day 1+ pk/day

Physician’s signature ___________________________________ Date________________