Quality Eye Center

Medical History Questionnaire

Name:_____ DOB: ___/____/_____ Date:___/____/____

List **ALL MAJOR ILLNESSES OR INJURIES** (diabetes, high blood pressure, heart attack, stroke, asthma ……)

_____

_____

_____

_____

List **ALL SURGERIES** you have had:

_____

_____

_____

ALLERGIES:_____

List **ALL MEDICATIONS** you currently take (prescription and over-the-counter, etc.)

_____

_____

_____

_____

Do you currently have any problems in the following areas? If yes, please explain:

SYSTEM	**YES**	**NO**	**Explanation of problem**
EYES (retinal diseases, glaucoma, etc…)			
Or any other eye problems…			
GENERAL/CONSTITUTIONAL…			
(fever, weight loss, other…)			
EARS, NOSE, THROAT…			
CARDIOVASCULAR (heart, vessels…)			
RESPIRATORY (asthma, emphysema…)			
GASTROINTESTINAL (stomach…)			
GENITAL, KIDNEY, BLADDER…			
MUSCLES, BONES, JOINTS (arthritis…)			
SKIN (skin cancer…)			
NEUROLOGICAL (multiple sclerosis…)			
PSYCHIATRIC (anxiety, depression…)			
ENDOCRINE (diabetes: including years, thyroid disease…)			
BLOOD (high cholesterol, anemia…)			
ALLERGIC/AUTOIMMUNE…			
OTHER…			

Quality Eye Center

FAMILY HISTORY **M=mother F=father S= sibling GP= grandparent**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
BLINDNESS			
GLAUCOMA			
MACULAR DEGENERATION			
OTHER EYE DISEASES			
DIABETES			
HEART DISEASE OR HIGH BLOOD PRESSURE			
CANCER			
STROKE			
KIDNEY DISEASE			
THYROID DISEASE			
OTHER			

SOCIAL HISTORY: **DO YOU DRIVE?** [ ]YES [ ]NO **DO YOU SMOKE?** [ ]YES [ ]NO

CURRENT OCCUPATION:_____

PATIENT/GUARDIAN'S SIGNATURE_____**DATE**:_____

PHYSICIAN'S SIGNATURE:_____**DATE**:_____

PLEASE READ OUR HIPAA COMPLIANCE/PRIVACY POLICY. A COPY IS AVAILABLE AT OUR FRONT DESK AND POSTED AT CHECK IN AND CHECK OUT STATIONS, OR ON OUR WEBSITE (www.qualityeyecenter.com)

We are required by law to maintain the privacy of, and provide individuals with, notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main number. Signature below is acknowledgement that you have read and understand the privacy practices:

Print name:_____ Signature:_____ Date:_____

The following people are authorized to receive and/or discuss my protected health information:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

We now prescribe medications electronically. Please fill in the following information:

Pharmacy name:_____

Pharmacy address:_____

Pharmacy phone number:_____