

Magruder Eye Institute

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY QUESTIONNAIRE

PATIENT: _____ DATE: _____

(circle where appropriate)	PATIENT		RELATIVE			PATIENT		RELATIVE	
	YES	NO	YES	NO		YES	NO	YES	NO
Infection/cough/fever in the past wk					Arthritis/Osteo/Rheumatoid/Juvenile				
Contagious diseases / HIV / AIDS					Sleep Apnea				
Chest Pain / Angina					Asthma/Emphysema / Bronchitis				
Heart Attack / CHF					Tuberculosis / Shortness of Breath				
Weakness/numbness in arms / legs					Epilepsy / Seizures / Stroke / TIA				
Pacemaker / Defib					Fainting / Headache / Migraines				
Heart Valve Disease / Murmur					Diabetes / Low Blood Sugar				
Fast Beat					Insulin Dependent x _____ years				
High Blood Pressure					Thyroid problems: Hyper-/Hypo-				
Ankle Swelling					Liver Disease/Jaundice/Hepatitis				
Psychiatric Disorder					Kidney Problems / Dialysis				
Anemia / Sickle Cell Anemia					Polio / Paralysis / Meningitis				
Bleeding Problems / Blood Clots					Other Diseases Not Listed				
Back Pain / Sciatica / Slipped Disc					Unusual Reaction to Anesthesia				
Cancer - Type					(Females) Pregnant / Nursing				

Do you Smoke? NO YES - Packs per Day? _____ Packs per Week _____

Do you drink Alcohol? NO YES - Drinks per Day? _____ Drinks per Week _____

Do you live alone? NO YES

AGE: _____ RACE: _____ SEX: M F HEIGHT: _____ WEIGHT: _____

List all **ALLERGIES/DESCRIBE REACTION:** (Include: Tape, Latex, IV Dye, and Medications) NONE _____

List all **PREVIOUS SURGERIES** (Include dates): NONE _____

List all **MEDICATIONS / NUTRITIONAL SUPPLEMENTS / HERBS / RECREATIONAL DRUGS** you take
(Include the *amounts* and *how often you take each* or attach a list) NONE Do you take ASPIRIN daily? Yes No

List your Primary Care Physician: _____ Phone: _____
Address _____ Date of last visit: _____

Person to contact in case of an Emergency? _____

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history.

Patient's signature: _____ **Date** _____

The bottom section will be completed for surgery patients only.

WHO WILL BE TAKING YOU HOME AFTER SURGERY? _____ Phone: _____

Medical Clearance Required? YES NO

Medical History Information Reviewed With The Patient and Agreed Correct.

SEE PHYSICAL EXAM DONE AT THE AMBULATORY SURGICAL CENTER

Comments: _____

SURGEON'S SIGNATURE _____ **Date** _____

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Your Eye History

Have you been diagnosed with any of the following in the past? Note the how long you have been aware of these.
 F=father M=mother (P=paternal M=maternal) S=sister B=brother GF=grandfather GM=grandmother U=uncle A=aunt

	PATIENT		RELATIVE		COMMENTS	LIST ALL EYE SURGERIES/DATE
	YES	NO	YES	NO		
Cataracts						
Retinal disease						
Crossed Eyes						
Iritis or Inflammation of the eyes						
Corneal Disease						
Glaucoma						
Eye Injury						
Macular degeneration						
Retinitis Pigmentosa						
Diabetic Retinopathy						
Retinal Detachment						
Other eye problems						

Cataract Surgery (Date of Surgery) Right Eye _____ Left Eye _____

Technician signature: _____

Initial review date: _____

Doctor signature: _____

Initial review date: _____

FOR OFFICE USE ONLY

DATE REVIEWED/TECH	DATE REVIEWED/TECH	DATE REVIEWED/TECH	DATE REVIEWED/TECH

A NEW HEALTH HISTORY FORM SHOULD BE COMPLETED ANNUALLY