Magruder Eye Institute

TODAYS DATE: ________________

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY QUESTIONNAIRE

PATIENT FULL NAME: ___________________________________ DATE OF BIRTH: _____________

	PATIENT		RELATIVE			PATIENT		RELATIVE	
(CIRCLE WHERE APPROPRIATE)	YES	NO	YES	NO	**(CIRCLE WHERE APPROPRIATE)**	YES	NO	YES	NO
Infection / Cough / Fever in the past week					Arthritis/Osteo/Rheumatoid/Juvenile				
Contagious Disease : 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 Fast Beat					Diabetes/Low Blood Sugar				
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 Disease(s) not listed:				
Back Pain/Sciatica/Slipped Disc					Unusual Reaction to Anesthesia				
Cancer-Type:					Pregnant/Nursing (Females)				

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 (please include dose amounts and frequency)

NONE ☐ Do you take ASPIRIN daily? YES ☐ NO ☐

____

____

____

List your Primary Care Physician: _________________________ **Phone Number:** _________________

Address: ____ Date of Last Visit: _______________

Person to contact in case of an Emergency? ____

Phone Number: ______________________________ Relationship: __________________________

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

____

Patient Signature