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Excel Eye Care & Surgery Center

Date: / / 22

Medical History Questionnaire

Medical History

Name: _____

List all major illnesses and injuries _____

_____

List any surgeries you have had _____

_____

List all illnesses, injuries and surgeries to the eye _____

_____

List any medications you take (including ocular) _____

_____

Do you have any allergies to medications? ___ Yes ___ No

If yes, list medication(s) _____

Review of Systems – Do you have any problems in the following areas? If yes, provide information.

Explanation of Problem

Constitutional Problems-Fever, weight loss _____

Eyes-Loss of vision, blurred vision, distorted vision (halos), _____

Loss of side vision, double vision, dryness, mucous discharge, _____

Redness, sandy or gritty feeling, itching, burning, tired eyes, _____

Glare/light sensitivity, eye pain or soreness, chronic infection, _____

Difficulty **with** night vision _____

Ears, nose, mouth, throat-Sinus congestion, runny nose, _____

Post nasal drip, chronic cough, dry throat/mouth _____

Cardiovascular-Palpitations, chest pain _____

Respiratory-Chronic bronchitis, shortness of breath _____