James E. Haberman, M.D., F.A.C.S.
Excel Eye Care & Surgery Center

Date:___/_____/ 19

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 _____

Explanation of Problem

Musculoskeletal-Arthritis _____

Psychiatric _____

Allergic-Head allergy symptoms, seasonal of hay fever _____

Family History

Disease	Yes	No	Relationship to Patient
Glaucoma	___	___	_____
Macular Degeneration	___	___	_____
Retinal Problem	___	___	_____
Arthritis	___	___	_____
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Stroke	___	___	_____
Tuberculosis	___	___	_____
Other	___	___	_____

Social History

Do you drive? ___ Yes ___ No Do you smoke? ___ Yes ___ No

Do you wear glasses? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No If yes, ___ meals ___ socially __ other

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PHYSICIAN USE ONLY

History reviewed. ___ No changes. ___ Additions as noted above.

Signature: _____ Date: ___/_____/ 19