

**James E. Haberman, M.D., F.A.C.S.**

Excel Eye Care & Surgery Center

Date: \_\_\_ / \_\_\_ / 18

## 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**

<b>Disease</b>	<b>Yes</b>	<b>No</b>	<b>Relationship to Patient</b>
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: \_\_\_/\_\_\_/18

**Internet**