Mayfair Eye Associates

Medical History Questionnaire

Patient Name: _____

Address: _____

_____ Zip: _____

Phone: _____ DOB: _____

SSN: _____

Insurance: _____

Email: _____

Primary Care Physician/Medical Doctor Information

Name: _____

Address: _____

_____ Zip: _____

Phone: _____

Last Medical Exam: ____/____/____

Review of Systems

Do you currently, or have you ever had any problems in the following area:

	NO	YES	Unknown
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Stroke	☐	☐	☐
Seizures	☐	☐	☐
Alzheimer's	☐	☐	☐
Dementia	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Dry Eye	☐	☐	☐
Drooping eyelid	☐	☐	☐
Prominent eyes	☐	☐	☐
Cataracts	☐	☐	☐
Eye infections	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal disease	☐	☐	☐
Eye injuries	☐	☐	☐
Infectious Disease			
Hepatitis	☐	☐	☐
HIV	☐	☐	☐
Tuberculosis	☐	☐	☐
Herpes	☐	☐	☐
Syphilis	☐	☐	☐
Other	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid	☐	☐	☐
Other	☐	☐	☐
Psychiatric			
Depression or Anxiety	☐	☐	☐
Other	☐	☐	☐

	NO	YES	Unknown
Ears, Nose, Mouth, Throat			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
Hearing	☐	☐	☐
Other	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
COPD	☐	☐	☐
Cardiovascular Disease			
Heart Attack	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Other	☐	☐	☐
Gastrointestinal			
Diarrhea/Constipation	☐	☐	☐
Ulcers	☐	☐	☐
Other	☐	☐	☐
Genitourinary			
Genitals / Bladder	☐	☐	☐
Kidney Disease	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Bone or Joint Disease	☐	☐	☐
Other	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Cholesterol	☐	☐	☐
Immunologic			
Sarcoidosis	☐	☐	☐
Lupus	☐	☐	☐
Other	☐	☐	☐
Cancer/Tumor	☐	☐	☐

See other side

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: ____________________

List all major injuries, surgeries and/or hospitalizations you have had: ____________________

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Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? __________

Social History

This information is kept strictly confidential. However, you may discuss this directly with your doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe: ____________________

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long: ____________________

Do you drink alcohol? ☐ No ☐ Yes If more than socially, please describe: ____________________

Do you use recreational drugs? ☐ No ☐ Yes If yes, type/amount/how long: ____________________

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

DISEASE /CONDITION	NO	YES	Unknown
Blindness	☐	☐	☐
Cataract	☐	☐	☐
Crossed Eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment/Disease	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood pressure	☐	☐	☐
Kidney Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Other __________	☐	☐	☐

MEDICATIONS

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Doctor's Signature ____________________ Date ____________________

Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials