Palm Family Eyecare
201 Dakota Street
Sutherlin, OR 97479

MEDICAL HISTORY QUESTIONNAIRE

Name:_____Today's Date _____
Mailing Address_____
Box/Street City State Zip
Date of Birth_____SS#_____Home Phone_____
Email Address_____
Primary Care Physician_____Dr. Phone_____
Occupation_____Last Eye Exam_____Cell Phone_____
Primary Insurance_____Secondary Insurance_____
Spouse Name_____ Spouse Employer_____

Eye History

History of Eye Surgery_____History of Eye Infection_____
Do you or have you ever worn contacts? YES or NO Type and wearing schedule_____

Medical History

List any medications you take: _____
Are you allergic to any medications?_____
Do you currently have any of the following: (Circle the relevant option when it applies)

	No	Yes		No	Yes
Diabetes			Asthma/Emphysema/COPD		
High Blood Pressure			Rheumatoid Arthritis		
Heart Problem			Muscle/Joint pain/Arthritis		
High Cholesterol			Gastrointestinal Disorder		
Anemia/Bleeding disorder			Kidney/Bladder/Liver Disorder		
Thyroid/Endocrine disorders			Immunologic Disorder		
Seizures			Recent Weight Gain/Loss		
Skin Disorders			Allergies/ Hay Fever		
Headaches/Migraines			Psychiatric Disorders		
Cancer			Are you Pregnant		
Smoker/Tobacco Use			Alcohol/ Illegal Drug use		

Eye Problems

Glaucoma			Eye pain		
Macular Degeneration			Itching/Burning/Dryness		
Flashes/Floaters			Redness		
Excess tearing			Mucous Discharge		

***If you answered yes to any of the above or have a condition not listed, please explain:_____**
_____

Family History (Is there a history of the following in your family)

	No	Yes	Relationship		No	Yes	Relationship
Blindness			_____	Cancer			_____
Crossed Eyes			_____	Diabetes			_____
Glaucoma			_____	Heart Disease			_____
Macular Degeneration			_____	High Blood Pressure			_____
Retinal Detachments			_____	Thyroid Disease			_____

Patient or Guardian Signature _____ **Date**_____

Patient Review	Date	Initials	Provider Review	Date	Initials