Oregon
Eye Specialists, PC
PHYSICIANS & SURGEONS
DISEASES & MICROSURGERY OF THE EYE
www.oregoneyes.net

MEDICAL HISTORY QUESTIONNAIRE

Full Legal Name: _____ Sex: ☐ M ☐ F Age: _____ Date: _____

If this is your first visit, please complete:

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other: _____

Date of last eye exam: _____ Where was this done (doctor/clinic): _____

Primary Care Doctor: _____

Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Rapaflo
☐ Uroxatral ☐ Minipress ☐ Cardura ☐ Hytrin ☐ Avodart

Current Medications (prescription, over the counter, vitamins, homeopathic):

_____

_____

Allergies to medications: _____

_____

Have you ever had any of the following eye procedures: ☐ LASIK ☐ PRK ☐ RK

List **all current & previous** illnesses, injuries, surgeries:

_____

_____

Please check any of the conditions that you have **today**:

General:	☐ fever	☐ fatigue	☐ cancer	
Ears, Nose, Throat:	☐ earache	☐ nasal congestion	☐ pain	
Cardiovascular:	☐ chest pain	☐ high blood pressure	☐ irregular/rapid heartbeat	
Respiratory:	☐ asthma	☐ emphysema	☐ shortness of breath	
Gastrointestinal:	☐ reflux	☐ diarrhea	☐ vomiting	
Genitourinary:	☐ trouble urinating	☐ discharge	☐ ulcer	
Integumentary:	☐ skin cancer	☐ acne	☐ rosacea	☐ eczema
Musculoskeletal:	☐ arthritis	☐ gout	☐ joint or muscle pain	
Neurological:	☐ numbness	☐ memory loss	☐ dizziness	☐ stroke
Psychiatric:	☐ anxiety	☐ depression		
Endocrine:	☐ diabetes	☐ hypothryroidism	☐ Grave's disease	
Hematologic:	☐ high cholesterol	☐ anemia	☐ bleeding disorder	
Immunologic:	☐ allergies	☐ immune disorders		

Do any of your blood relatives have the following conditions:

Blindness	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Social History:

Do you currently drive?	☐ No	☐ Yes				
Do you currently smoke?	☐ No	☐ Yes	How much?	☐ 1 pack/day or less	☐ 1 pack/day	☐ 2+ packs/day
Have you ever smoked?	☐ No	☐ Yes	When did you quit? _____			
Are you pregnant?	☐ No	☐ Yes	Expected due date? _____			
Are you working?	☐ No	☐ Retired	☐ Yes, occupation? _____			