Medical History Questionnaire

Please list all current medications:_____

_____

_____

Pharmacy:_____ City:_____ State:_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:_____

List all major surgeries or injuries you have had:_____

_____

_____

Have you ever been diagnosed with any eye problem? ☐ Yes ☐ No

If yes, please list:_____

Are you pregnant? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

If yes, please list contact lens brand:_____

- **Family History-** Check all that apply

☐ Blindness
☐ Cataract
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Diabetes
☐ Cancer
☐ Thyroid disease
☐ Arthritis
☐ High blood pressure
☐ Heart disease

- **Review of Systems-** Check all that apply currently and previously

Integumentary:
☐ Eczema
☐ Shingles

Neurological:
☐ Migraines
☐ Seizures

Endocrine:
☐ Thyroid dysfunction

ENT:
☐ Allergies/Hay Fever
☐ Sinus Congestion
☐ Runny Nose
☐ Post-Nasal Drip
☐ Chronic Cough
☐ Dry Throat/Mouth

Respiratory:
☐ Asthrha
☐ Chronic Bronchitis
☐ COPD

Vascular/Cardiovascular:
☐ Diabetes
☐ Heart Disease
☐ High blood pressure

Gastrointestinal:
☐ Stomach issues

Bones/Joints/Muscles:
☐ Rheumatoid Arthritis
☐ Muscle Pain
☐ Joint Pain

Lymphatic/Hematologic:
☐ Anemia

Other:
☐ Psychiatric
☐ Cancer
☐ Multiple Sclerosis
☐ Lupus
☐ HIV
☐ Hepatitis

PRIMARY EYE CARE
DR. JOE C KEA

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Patient Demographic Information Form

Patient Information

Name:_____ Today's Date:_____/_____/_____

Birth Date:_____/_____/_____ ☐ Male ☐ Female

Age:_____ Height:_____ Weight:_____ Social Security:_____-_____-_____

Employer/School:_____ Last Eye Exam:_____/_____/_____

Marital Status: ☐ Married (Spouse Name)_____

☐ Single ☐ Windowed ☐ Divorced

Contact Information

Billing Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Preferred Phone:_____ Alt. Phone:_____

Email:_____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Insurance ID #_____ Insurance Policy #_____

Policy Group #_____ Policy Group # _____

Policy Holder Name:_____ Policy Holder Name:_____

- **Review of Systems-** Check all that currently apply

☐ Blurred vision
☐ Burning
☐ Double vision
☐ Dryness
☐ Eye pain/soreness
☐ Floaters/spots
☐ Distorted vision
☐ Infection of eye/eyelid (chronic)
☐ Itching
☐ Loss of vision
☐ Redness
☐ Watery Eyes
☐ Sandy/gritty feeling
☐ Sensitivity to light