Eye Care for Tulsa, Inc
MEDICAL HISTORY QUESTIONNAIRE

LAST NAME	FIRST NAME	DOB	ACCT #
_____	_____	__ / __ / __	_____

MEDICAL HISTORY

Do you have, or have you ever had any of the following medical conditions?

YES NO Arthritis

YES NO Cancer
(If yes what kind? _____ How long ago?_____)

YES NO Emphysema

YES NO Asthma

YES NO High Blood pressure

YES NO Heart Disease (Type? _____)

YES NO Liver Disease

YES NO Kidney Disease

YES NO Diabetes last A1C: _____
(If yes how many years? _____ Which type? NIDDM / IDDM)

YES NO Bleeding Disorders (e.g. Anemia, etc)

YES NO Reflux/Heartburn/Other digestive_____

YES NO Sleep Apnea
(If yes do you use a C-PAP machine? _____)

YES NO Alzheimer's / Dementia
(Other neurological _____)

YES NO Mental Illness

YES NO Migraine Headaches

HAVE YOU EVER HAD ONE OF THE FOLLOWING INFECTIOUS DISEASES?

YES NO MRSA

YES NO Hepatitis

YES NO HIV-AIDS

YES NO Have you had a flu shot this season?

YES NO Tuberculosis

YES NO Herpes

YES NO Sexually Transmitted Disease

YES NO Have you had a pneumonia shot this season?

If you have something other than what is on the list provided above please list here: _____
_____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

This includes all over the counter supplements and vitamins, etc. If you have a LIST we would be happy to make a copy for our records.

Medication, Dosage, Times per day	Medication, Dosage, Times per day	Medication, Dosage, Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE COMPLETE BOTH SIDES OF FORM

MEDICAL ALLERGIES

Codeine Penicillin Sulfa Morphine Iodine IVP Dye

Other: _____

SURGICAL PROCEDURES

Please list ALL surgical procedures that you have had

Type of procedure	When?	Type of procedure	When?

SOCIAL HISTORY

Do you **currently** smoke? YES / NO (If yes how many packs/day? ____ For how many years? ____)

Have you **ever** smoked? YES / NO (If yes how many packs/day? ___ For how many years? ____
When did you quit? _____)

Do you use any form of "recreational drug" or have you been addicted to any drug? YES / NO

Do you drink alcoholic beverages? (Circle one) Never Occasional Daily (Drinks per day____)

FAMILY MEDICAL HISTORY: (parents, siblings, grandparents, etc)

SYSTEMIC:	CIRCLE		RELATIONSHIP TO PATIENT
Diabetes	YES	NO	
Heart disease	YES	NO	
High blood pressure	YES	NO	
Stroke	YES	NO	
Cancer	YES	NO	
Lupus	YES	NO	
Rheumatoid arthritis	YES	NO	

OCULAR:	CIRCLE		RELATIONSHIP TO PATIENT
Corneal disease	YES	NO	
Corneal transplant	YES	NO	
Glaucoma	YES	NO	
Cataracts	YES	NO	
Retinal detachment	YES	NO	
Macular degeneration	YES	NO	

_____ _____

Patient Signature **Date**

_____

Guardian Signature (if needed)

*** *To ensure proper care for all of our patients, please fill out this entire form to the best of your ability. Thank you!* ***