Shapiro Eye Care

CORNERSTONE HEALTH CARE

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

(All responses are confidential medical information)

Name: _____ Date of Birth: _____

Who referred you? _____

Family Physician: _____ Date of Last Eye Exam: _____

Email Address: _____

1. Eyes	Yes	No
Blurred Vision	❑	❑
Loss of Vision	❑	❑
Flashes and Floaters	❑	❑
Glare	❑	❑
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Itching	❑	❑
Burning	❑	❑
Foreign Body	❑	❑
Eye Pain	❑	❑

Other: _____

2. General	Yes	No
Fever	❑	❑
Weight loss	❑	❑

Other: _____

3. Ear, Nose, Throat	Yes	No
Sinus problems	❑	❑

Other: _____

4. Cardiovascular	Yes	No
Heart problems	❑	❑
Chest pain	❑	❑
High blood pressure	❑	❑

Other: _____

5. Respiratory	Yes	No
Asthma	❑	❑
Shortness of breath	❑	❑
Chronic cough	❑	❑
Emphysema	❑	❑

Other: _____

6. Gastrointestinal	Yes	No
Acid reflux	❑	❑

Other: _____

7. Genital, Kidney, Bladder	Yes	No
Kidney failure	❑	❑

Other: _____

8. Muscles, Bones, Joints	Yes	No
Arthritis	❑	❑

Other: _____

9. Skin	Yes	No
Acne	❑	❑
Skin cancer	❑	❑

Other: _____

10. Neurological	Yes	No
Headache	❑	❑
Seizure	❑	❑
Stroke	❑	❑
Alzheimer's	❑	❑

Other: _____

11. Psychiatric	Yes	No
Anxiety	❑	❑
Depression	❑	❑

Other: _____

12. Endocrine	Yes	No
Diabetes	❑	❑
Insulin	❑	❑
Oral Meds	❑	❑
Diet Controlled	❑	❑
Thyroid disease	❑	❑

Other: _____

13. Blood, Lymph	Yes	No
Cholesterol	❑	❑
Anemia	❑	❑

Other: _____

14. Allergic, Immunologic	Yes	No
Seasonal allergies	❑	❑
Lupus	❑	❑
AIDS	❑	❑

Other: _____

MEDICATIONS

- List all medications you currently take (***include eye medications and drops***):

_____

_____

_____

_____

_____

DRUG ALLERGIES

- List any drug allergies you have below:

_____

_____

_____

- Are you allergic to: Latex ❑ Yes ❑ No Betadine ❑ Yes ❑ No Shellfish ❑ Yes ❑ No

PREVIOUS EYE SURGERY

- Include dates and the doctor that performed the surgery.

_____

_____

_____

_____

FAMILY HISTORY

- Have any of your parents, grandparents or siblings had any of the following?

	Yes	No	Relationship
Cataract	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Detachment	❑	❑	_____
Diabetes	❑	❑	_____
High Blood Pressure	❑	❑	_____
Stroke	❑	❑	_____
Heart Problems	❑	❑	_____
Cancer	❑	❑	_____

Other: _____

MISCELLANEOUS

- Do you wear glasses? ❑ Yes ❑ No How Long?_____
- Do you wear contact lens? ❑ Yes ❑ No How Long?_____
- Do you smoke? ❑ Yes ❑ No
- Do you drink alcohol? ❑ Yes ❑ No
- Are you interested in Lasik Eye Surgery? ❑ Yes ❑ No

History Reviewed By: _____ _____

Physician's Signature Date