Date of Visit: ______________________________

Patient's Name: ______________________________

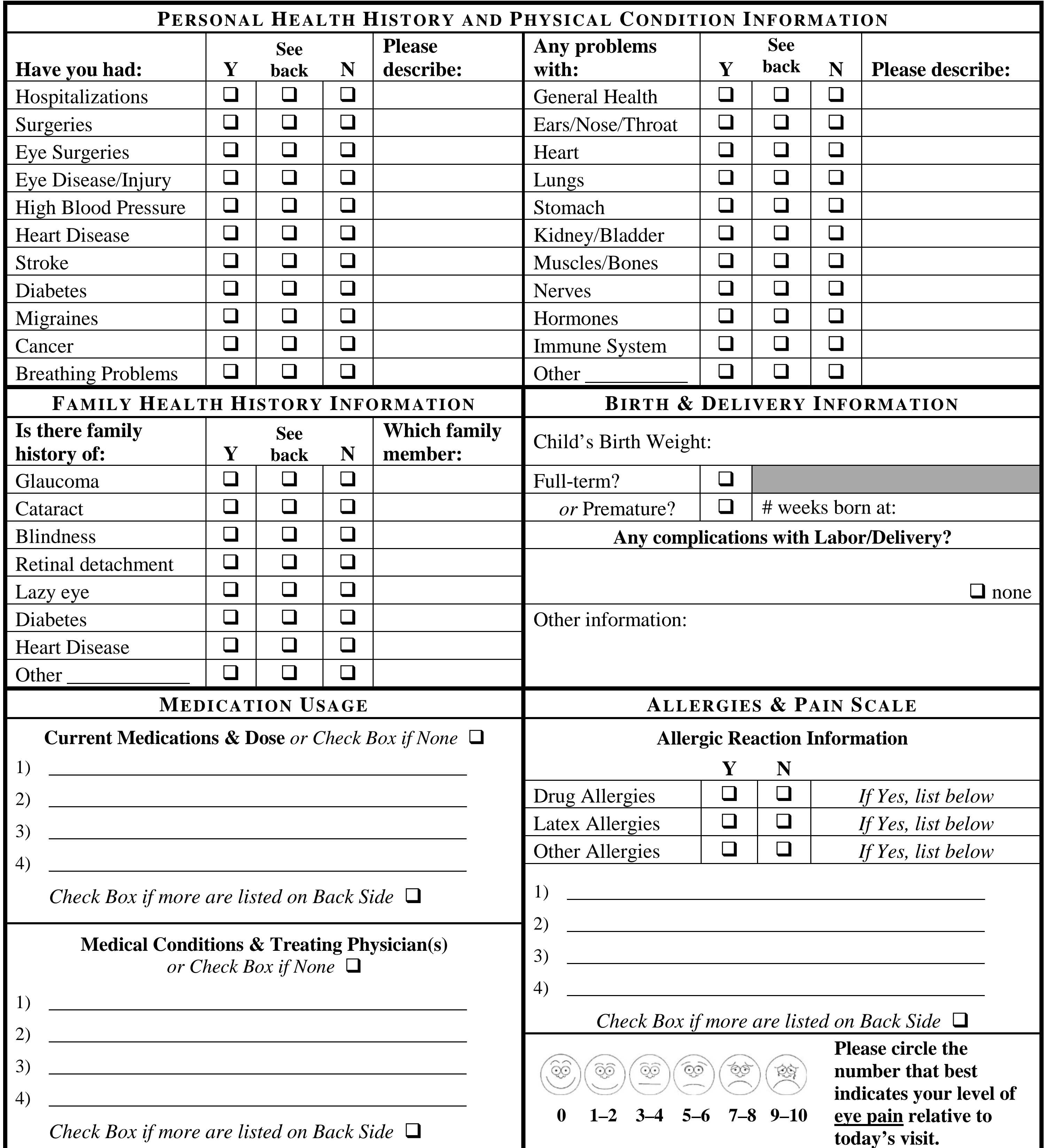
Date of Birth: ______________________________

Flaum Eye Institute at the University of Rochester

Faculty Practice

Patient Medical History Questionnaire

Use back of form if more space is needed



PERSONAL HEALTH HISTORY AND PHYSICAL CONDITION INFORMATION

Have you had:	Y	See back	N	Please describe:	Any problems with:	Y	See back	N	Please describe:
Hospitalizations	❑	❑	❑		General Health	❑	❑	❑	
Surgeries	❑	❑	❑		Ears/Nose/Throat	❑	❑	❑	
Eye Surgeries	❑	❑	❑		Heart	❑	❑	❑	
Eye Disease/Injury	❑	❑	❑		Lungs	❑	❑	❑	
High Blood Pressure	❑	❑	❑		Stomach	❑	❑	❑	
Heart Disease	❑	❑	❑		Kidney/Bladder	❑	❑	❑	
Stroke	❑	❑	❑		Muscles/Bones	❑	❑	❑	
Diabetes	❑	❑	❑		Nerves	❑	❑	❑	
Migraines	❑	❑	❑		Hormones	❑	❑	❑	
Cancer	❑	❑	❑		Immune System	❑	❑	❑	
Breathing Problems	❑	❑	❑		Other ___________	❑	❑	❑	

FAMILY HEALTH HISTORY INFORMATION

Is there family history of:	Y	See back	N	Which family member:
Glaucoma	❑	❑	❑	
Cataract	❑	❑	❑	
Blindness	❑	❑	❑	
Retinal detachment	❑	❑	❑	
Lazy eye	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
Other _____________	❑	❑	❑	

BIRTH & DELIVERY INFORMATION

Child's Birth Weight:		
Full-term?	❑	
or Premature?	❑	# weeks born at:

Any complications with Labor/Delivery?

❑ none

Other information:

MEDICATION USAGE

Current Medications & Dose *or Check Box if None* ❑

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

Check Box if more are listed on Back Side ❑

Medical Conditions & Treating Physician(s)
or Check Box if None ❑

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

Check Box if more are listed on Back Side ❑

ALLERGIES & PAIN SCALE

Allergic Reaction Information

	Y	N	
Drug Allergies	❑	❑	*If Yes, list below*
Latex Allergies	❑	❑	*If Yes, list below*
Other Allergies	❑	❑	*If Yes, list below*

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

Check Box if more are listed on Back Side ❑

0 1–2 3–4 5–6 7–8 9–10

Please circle the number that best indicates your level of eye pain relative to today's visit.

Reviewed by: ____________________ **MD** *Date:* ______________

Thank you for taking the time to complete this form

Please list additional information below: