

Miramar Eye Specialists Medical Group

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New Patient Medical History Questionnaire

Name _____ Date of birth _____ Today's date _____

Date of your last eye exam _____ With whom? _____

List any medications you currently take (prescription and over-the-counter) _____

Do you have allergies to any medications? No Yes If "yes," list the medications _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) and/or injuries (concussion, etc) _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____

Do you currently have any problem in the following areas? If "yes," please provide details.			
Condition	No	Yes	Details
Eyes			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eye; lazy eye			
Drooping eyelid			
General/Constitution: Fever, weight loss, other			
Ears/Nose/Throat: Stuffy nose, earache, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, racing pulse, etc.			
Respiratory: Congestion, wheezing, asthma, etc.			
Gastrointestinal: Upset stomach, diarrhea, constipation, etc.			
Genital/Kidney/Bladder: Painful urination, frequent urination, impotence, etc.			

- Please complete side 2 -

