Robert R. Palozej OD, LLC
Advanced Eyecare
Medical History Questionnaire

Please fill out all information to the best of your ability!
We apologize for this inconvenience, but due to changes in computer systems and insurance company requirements, we cannot efficiently care for you without this data.

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

Address: ____ Home Phone: ________________

City ______________________ State ______ Zip Code ________ Work / Cell Phone: ____________

Birth Date: _____/_____/______ Social Security #: _____-____-_____ Employer/School: ______________

Occupation______________________ Sex M F Marital Status M D S W

Medical History Name of Medical Doctor: ___________________ Last Medical Exam: ____/____/_____

Doctor's town location and phone number________________________________ _______-___________

Are you PREGNANT or Nursing? Yes No Current Pharmacy________________#______-__________

Do you have ALLERGIES to medications? Yes No If yes, list: ______________________________
List any Medications you take (including oral contraceptives, aspirin, over the counter and/or home remedies):
____

List all **Major** injuries, surgeries, and/or hospitalizations you have had: ____________________________
____

Personal Eye History Circle any of the following that you have had: Eye Injury Eye Surgery Cataract Glaucoma Macular Degeneration Retinal Disease Crossed Eyes Lazy Eye Drooping Eyelid
Other: ____

Family History (parents, grandparents, siblings, children; living or deceased)

DISEASE/CONDITIONS			**Relationship To You**
Blindness	Yes	No	______________________
Cataract	Yes	No	______________________
Crossed Eyes	Yes	No	______________________
Glaucoma	Yes	No	______________________
Macular Degeneration	Yes	No	______________________
Retinal Detachment/Disease	Yes	No	______________________
Arthritis	Yes	No	______________________
Diabetes	Yes	No	______________________
Heart Disease	Yes	No	______________________
Thyroid Disease	Yes	No	______________________
Other	Yes	No	______________________

Please Turn This Form Over And Complete Side Two

Social History This information is kept strictly confidential. However, if you would prefer to speak directly to the Doctor, circle YES. Otherwise, please answer the following questions:

Do you use tobacco products? Yes No If yes, type/amount/for how long: ____________________
Do you drink alcohol? Yes No If yes, type/amount/for how long: ____________________
Do you use illegal drugs? Yes No If yes, type/amount/for how long: ____________________
Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Yes No ??

Review of Systems Have you ever been **SEEN BY A DOCTOR** for any of the following conditions??

Constitutional

Fever, Weight Loss / Gain	Yes	No	??
Dermatology (Skin)	Yes	No	??
Neurological			
Headaches	Yes	No	??
Migraines	Yes	No	??
Seizures	Yes	No	??
Eyes			
Loss of Vision	Yes	No	??
Loss of Side Vision	Yes	No	??
Distorted Vision / Halos	Yes	No	??
Double Vision	Yes	No	??
Itching / Burning	Yes	No	??
Sandy or Gritty Feeling	Yes	No	??
Foreign Body Sensation	Yes	No	??
Eye Pain or Soreness	Yes	No	??
Excess Tearing / Watering	Yes	No	??
Glare / Light Sensitivity	Yes	No	??
Tired Eyes	Yes	No	??
Mucous Discharge	Yes	No	??
Flashes / Floaters in Vision	Yes	No	??
Stye or Chalazion	Yes	No	??
Endocrine			
Thyroid / Other Glands	Yes	No	??
Psychiatric	Yes	No	??
Allergic / Immunologic	Yes	No	??
Ear, Nose, Mouth, Throat			
Allergies / Hay Fever	Yes	No	??
Sinus Congestion	Yes	No	??
Runny Nose	Yes	No	??
Post-Nasal Drip	Yes	No	??
Chronic Cough	Yes	No	??
Dry Throat / Mouth	Yes	No	??
Respiratory			
Asthma	Yes	No	??
Chronic Bronchitis	Yes	No	??
Emphysema	Yes	No	??
Vascular / Cardiovascular			
Diabetes	Yes	No	??
Heart Attack/Pain	Yes	No	??
High Blood Pressure	Yes	No	??
Vascular Disease	Yes	No	??
Gastrointestinal			
Diarrhea/ Constipation	Yes	No	??
Genitourinary			
Genitals / Kidney / Bladder	Yes	No	??
Bones / Joints / Muscles			
Muscle/Joint Pain	Yes	No	??
Rheumatoid Arthritis	Yes	No	??
Lymphatic / Hematologic			
Bleeding Problems	Yes	No	??
Anemia	Yes	No	??

If you answered YES to any of the above or have a condition not listed, please explain to Doctor Palozej.

I understand that the information that I have given today is correct to the best of my knowledge. I also know that this information will be held in the strictest confidence and that it is MY responsibility to inform this office of any changes. I authorize the doctor's optometric staff to perform any optometric service with my consent.

Patient		Doctor	Patient		Doctor
Signature____________	Date__/__/__	____________	Signature____________	Date__/__/__	____________
Signature____________	Date__/__/__	____________	Signature____________	Date__/__/__	____________
Signature____________	Date__/__/__	____________	Signature____________	Date__/__/__	____________
Signature____________	Date__/__/__	____________	Signature____________	Date__/__/__	____________