NORTHERN ILLINOIS EYE CLINIC

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient name: _____Today's date____/____/_____

Address_____ Preferred phone_____

City_____State_____Zip_____

Birth date____/_____/_____ Marital Status_____

Occupation:_____Email_____

Emergency contact_____ phone_____

Relationship to patient_____ __How did you hear about us?_____

Primary Care Dr_____

Last eye exam_____ Last Eye Doctor_____

Guardian or POA_____Relationship_____

Medical History

Allergies to medication ☐NO ☐YES if yes please explain _____

_____

Are you allergic to Latex? ☐NO ☐YES

Please list any of the following EYE problems you have had: crossed eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury:

_____

Please list all **EYE Surgeries** you have had: _____

Please list all **EYE DROPS** you are using:_____

Please list all medications you are taking (including aspirin, oral contraceptives, over-the-counter medications, vitamins, etc.) or attach a list. Continue on reverse side if needed.

MEDICATION	TAKEN FOR	DOSAGE	DOSES/DAY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all Medical diagnoses, Surgeries, and Injuries you have had: (continue on reverse side)

Medical problem	Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you pregnant or nursing? ☐NO ☐YES
Have you ever been exposed to or infected with:
☐ Gonorrhea ☐ Hepatitis ☐HIV ☐ Syphilis

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms or diseases?

	NO	YES
CONSTITUTIONAL		
Fever	☐	☐
Recent weight loss	☐	☐
INTEGUMENTARY (SKIN)		
Eczema	☐	☐
Rash	☐	☐
Itching	☐	☐
NEUROLOGICAL		
Headache	☐	☐
Migraines	☐	☐
Dizziness	☐	☐
Seizures	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid problems	☐	☐
Other Gland	☐	☐
EARS, NOSE, THROAT		
Seasonal allergies	☐	☐
Sinus congestion	☐	☐
Loss of hearing	☐	☐
Chronic cough	☐	☐
Dry mouth	☐	☐
Have you ever been diagnosed with CANCER?	☐	☐

	NO	YES
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Chest pain	☐	☐
High Blood pressure	☐	☐
Racing pulse	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Vomiting	☐	☐
Ulcers	☐	☐
GENITOURINARY		
Kidney stones	☐	☐
Genital ulcers	☐	☐
Incontinence	☐	☐
BONES, JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle pain/weak	☐	☐
Joint pain/weakness	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding/bruising	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Memory loss	☐	☐
Nervousness/panic attacks	☐	☐

Please list any other conditions not previously listed presently or in the past:
_____

Patient's Signature: _____ Date:_____/_____/_____

Doctor's signature_____Date: _____/_____/_____