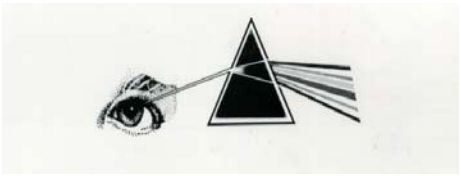
# Cochise Eye & Laser



## New Patient Medical History Questionnaire

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you with the most complete medical care possible.

### General

| Name | Birth Date | Date of Visit |
|---|---|---|
| | | |

### Past and Present Medical Conditions: *Check all that apply. Write in if not listed.*

[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Emphysema
[ ] Diabetes: [ ] Type 1 [ ] Type 2
[ ] Blood Clotting Disorder
[ ] Arthritis
[ ] Bronchitis
[ ] Heart Disease: [ ] Prior Heart Attack [ ] Irregular Heartbeat
[ ] Stomach Ulcers
[ ] Gastro Reflux (heartburn)
[ ] Asthma
[ ] Cancer (location): _____
[ ] Prior Stroke
[ ] Kidney Disease/ Failure
[ ] Kidney Stones
[ ] Thyroid Disorder: [ ] Hyperthyroid [ ] Hypothyroid
[ ] Allergies (hay fever)
[ ] Chronic Infection: [ ] Hepatitis [ ] HIV / AIDS [ ] Resistant Staph
[ ] Other: _____
[ ] Other
[ ] Other
[ ] Other

### Prior Surgeries / Hospitalizations: *List all previous surgeries and hospitalizations by date.*

| Month/Year | Surgery Performed / Reason for Hospitalization: |
|---|---|
| | |
| | |
| | |
| | |
| | |

### Medications: *List all prescription and non-prescription medications you are currently taking. Write **none** if taking no medications.*

| | | | |
|---|---|---|---|
| 1. | 4. | 7. | 10. |
| 2. | 5. | 8. | 11. |
| 3. | 6. | 9. | 12. |

### Allergies: *List all known allergies to medications and food, and the reaction they cause. Write **none** if you do not have any allergies.*

| Medication / Food | Reaction |
|---|---|
| | |
| | |
| | |
| | |

### Family Eye Disease History: *Check all that apply and describe how related.*

| Condition | Relationship | Condition | Relationship |
|---|---|---|---|
| [ ] Cataract | | [ ] Cornea Transplant | |
| [ ] Glaucoma (high pressure) | | [ ] Misaligned (crooked eye) | |
| [ ] Macular Degeneration | | [ ] Vision Loss - uncertain cause | |
| [ ] Diabetic Eye Disease | | [ ] Other: | |

### Social History: *Answer the following questions.*

1. Does your vision limit any activities of daily living? [ ] Yes [ ] No *If yes, mark which activities.*
   [ ] Driving [ ] Reading [ ] Watching Television [ ] Computer Work [ ] Other:
2. Do you drink alcohol? [ ] Yes [ ] No *If yes, how much?* _____
3. Do you smoke? [ ] Yes [ ] No *If yes, how much?* _____
4. Please list any other recreational drug use:

## Current Symptoms

*Please circle any symptoms you are currently experiencing. If normal, circle* **none**.

**Head:** none headache fever earache runny nose sore throat other: _____

**Heart:** none chest pain palpitations other: _____

**Lungs:** none shortness of breath cough phlegm (clear, yellow, red) other: _____

**Gastrointestinal:** none nausea vomiting diarrhea heartburn constipation

other: _____

**Urinary:** none trouble urinating frequent urination painful urination blood in urine

other: _____

**Muscle / Joint:** none muscle pain joint pain location: _____ other: _____

**Skin:** none rash bruise open wound mole location: _____ other: _____

**Neurological:** none numbness tingling weakness tremor other: _____

**Psychological:** none depression anxiety hallucinations other: _____

**Allergic:** none sneezing runny nose tearing other: _____

**Blood:** none persistent bleeding location: _____

**Constitutional:** none fatigue weight loss night sweats poor appetite trouble sleeping
other: _____

**Other:** _____

_____

**Physician's Notes:** _____

_____

_____

_____

_____

_____ _____

Physician's Signature Date