Palm Coast Eye Physicians

Martin M Pourkesali D.O.

Medical History Questionnaire **Date:**

Patient's Name: Date of birth:
If Minor, Parents' Names:
Reason For Visit:

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

Do you have any allergies or reactions to medications? No Yes (explain)

Please list all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, eye injuries, etc.)

Please list any surgeries you have had (cataract, tonsillectomy, appendectomy, etc).

Birth History
(if patient is a minor) birth weight: number of siblings: brother(s)
gestation (wks): sister(s)
delivery: normal Caeserian

Do you currently have any problems in the following areas:

			Explanation or comments
Eye conditions or injuries			
Loss of vision	Yes	No	
Blurred vision	Yes	No	
Distorted vision	Yes	No	
Loss of side vision	Yes	No	
Double vision	Yes	No	
Dryness	Yes	No	
Mucous discharge	Yes	No	
Redness	Yes	No	
Sandy or gritty feeling	Yes	No	
Itching	Yes	No	
Burning	Yes	No	
Foreign body sensation	Yes	No	
Excess tearing/watering	Yes	No	
Glare/light sensitivity	Yes	No	
Eye pain or soreness	Yes	No	
Infection of eye or eyelid	Yes	No	
Tired eyes	Yes	No	
Crossed eyes, lazy eye	Yes	No	
Drooping eyelid	Yes	No	

Explanation or comments

General/Constitutional conditions

Fever	Yes	No	
Weight loss	Yes	No	
Other	Yes	No	
Ears, Nose, Throat(Sinus, ear infection, cough, dry mouth, etc.)	Yes	No	
Cardiovascular (heart, vessels, etc)	Yes	No	
Respiratory (Asthma, emphysema, etc.)	Yes	No	
Gastrointestinal (stomach ulcers, bowel disease, etc)	Yes	No	
Genital, Kidney, Bladder	Yes	No	
Muscles, Bones, Joints (arthritis, etc.)	Yes	No	
Skin (acne, warts, skin cancer, etc)	Yes	No	
Neurological (multiple sclerosis, etc)	Yes	No	
Psychiatric (anxiety, depression, insomnia, etc.)	Yes	No	
Endocrine (diabetes, thyroid, etc.)	Yes	No	
Blood/Lymph (cholesterol, anemia, etc.)	Yes	No	
Allergic/Immunologic (hay fever, lupus, etc.)	Yes	No	

Family History M = mother F = father S = sibling GP = grandparent

Condition			Relationship to patient			
Blindness	Yes	No	M	F	S	GP
Amblyopia (lazy eye)	Yes	No	M	F	S	GP
Strabismus (eye turning in or out)	Yes	No	M	F	S	GP
Glaucoma	Yes	No	M	F	S	GP
Arthritis	Yes	No	M	F	S	GP
Cancer	Yes	No	M	F	S	GP
Diabetes	Yes	No	M	F	S	GP
Heart disease or high blood pressure	Yes	No	M	F	S	GP
Kidney disease	Yes	No	M	F	S	GP
Lupus	Yes	No	M	F	S	GP
Stroke	Yes	No	M	F	S	GP
Thyroid disease	Yes	No	M	F	S	GP
Other	Yes	No	M	F	S	GP

Social History

Current occupation

Education (high school, vocational school, college degree)

Marital status (married, divorced, single, widowed)

Do you drive?	Yes	No	
Do you have visual difficulty driving?	Yes	No	
Do you have problems with night vision?	Yes	No	
Have you ever tried to wear contact lenses?	Yes	No	
Do you currently wear contact lenses?	Yes	No	How long?
Do you currently wear glasses?	Yes	No	How old are these glasses?
Do you drink alcohol?	Yes	No	How many drinks per day?
Do you smoke?	Yes	No	How many packs per day?
Have you ever had a blood transfusion?	Yes	No	

Signature of patient or guardian: Date:

History reviewed:❑

Physician's signature: Date: