Alkek Eye Center
of Baylor College of Medicine

MEDICAL QUESTIONNAIRE

Date:____________________
Day Month Year

Please answer these questions as completely as you can. We realize that this form is long, but the information in this form will be extremely valuable to us in providing you the best possible care.

Patient's Name:____
Last First Middle

Social Security No.:_____-_____-_____ Driver's License No.:____________________

Date of Birth:____________________ Patient's Sex: M ___ F___ Race:______________
Day Month Year

Patient's Address:____

Home Phone No.:____________________ Work Phone No.:____________________

Patient's Occupation:____________________ Employer:____________________

Emergency Contact:____________________ Phone No.:____________________

Relationship to Patient:____________________

IF OTHER THAN THE PATIENT, WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES?

Name:____
Last First Middle

Address:____
Street City State Zip Code

Home Phone No.:____________________ Relationship to Patient:____________________

Employer:____________________ Work Phone No.:____________________

WHO SENT YOU TO US OR FROM WHAT SOURCE DID YOU GET OUR NAME? (circle you choice)

Physician Family / Friend Baylor Referral Service Yellow PagesOther

IF PHYSICIAN REFERRAL, PLEASE PROVIDE ADDITIONAL INFORMATION:

Physician:______________________________ Phone No.:____________________

Address:____
Street City State Zip Code

Department of Ophthalmology
7200B Cambridge Houston, Texas 77030
telephone: 713-798-6100 fax: 713-798-4231

NAME:______________________________MR#_________________DATE:_________________
Day Month Year

EYE HISTORY

List all eye diseases / conditions that your have, and indicate how long you have had them.

Right eye condition	Month / Year of diagnosis	Left eye condition	Month / Year of diagnosis

EYE SURGERY

Have you had surgery on your eyes? No___ Yes___ If yes, please complete the following:

Right eye condition	Month/Year	Left eye condition	Month/Year

EYE MEDICATIONS:

What prescription and over-the-counter eye medicines are you using? Please indicate which eye, the number of times per day, and the duration that you have been using each drop, ointment, or oral medication.

Medication	Eye (circle choice)	No. times per day	For how long
	Right Left Both		
	Right Left Both		
	Right Left Both		
	Right Left Both		
	Right Left Both		
	Right Left Both		

Do you wear glasses? No___ Yes___ If yes, for how long?___________ Date last changed:__________

Do you wear contact lenses? No___ Yes___ If yes, what type and for how long?___________________

Did you even have patches placed on your eyes when you were a child or have you been told that you had crossed eyes or a lazy eye? No___ Yes___ If yes, describe:_______________________________
____

NAME:_______________________________MR#_________________DATE:_________________

Day Month Year

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.) in chronological order, if possible. (Do not include eye conditions that you have previously listed.)

Condition:___________________________Month/Year of diagnosis:___________________________
Condition:___________________________Month/Year of diagnosis:___________________________
Condition:___________________________Month/Year of diagnosis:___________________________
Condition:___________________________Month/Year of diagnosis:___________________________
Condition:___________________________Month/Year of diagnosis:___________________________
Condition:___________________________Month/Year of diagnosis:___________________________

Please list all previous surgical procedures (not involving your eyes) and their dates:

Surgical Procedure	Month / Year

MEDICATIONS:

Please list all medications that your are currently taking and their dosage (if known):

Medication	Dose	No. times per day	For how long

Are you taking aspirin or any other over-the-counter medicines? No___ Yes___ If yes, list:

____

____

Do you have any known drug allergies? No___ Yes___ If yes, list:

____

____

NAME:________________________ MR#______________ DATE:______________
Day Month Year

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	No	Yes
General		
Fever	______	______
Unexplained weight loss	______	______
Night sweats	______	______
Ear, nose, or throat		
Ringing in ears	______	______
Hearing loss	______	______
Pain	______	______
Nervous System		
Headache	______	______
Stroke	______	______
Seizure / epilepsy	______	______
Weakness, numbness, tingling	______	______
Heart or circulatory problems		
Heart attack or heart failure	______	______
Irregular heart rhythm	______	______
Chest pain	______	______
Pacemaker	______	______
Hypertension	______	______
Endocrine		
Thyroid disease	______	______
Diabetes	______	______
Hormonal disease	______	______
Allergy / immunology		
Environmental allergies	______	______
Iodine allergy	______	______
Contrast material (dye) allergy	______	______
Cat scratch or cat bite	______	______
Skin / breast		
Masses / tumors	______	______
Rash	______	______
Discharge from breast	______	______

	No	Yes
Lungs / breathing		
Breathing difficulty	______	______
Asthma	______	______
Lung disease	______	______
Digestive system		
Diarrhea	______	______
Ulcer disease	______	______
Hepatitis	______	______
Genitourinary		
Kidney disease	______	______
Urinary tract infection	______	______
Urinary bleeding	______	______
Altered menses	______	______
Blood		
Anemia (low blood count)	______	______
Blood tumors / disease	______	______
Swollen glands	______	______
Bleeding disorder	______	______
Musculoskeletal	______	______
Joint pain / arthritis		
Fractured bones	______	______
Pain with chewing	______	______
Scalp pain or tenderness	______	______
Psychiatric		
Depression	______	______
Mood swings	______	______
Anxiety	______	______
Admission to hospital psychiatric illness	______	______
Other:______________	______	______
______________	______	______
______________	______	______

COMMENTS:____
____
____
____
____
____

NAME:______________________________**MR#**_________________**DATE:**_________________

Day Month Year

PERSONAL HISTORY

Are you: (circle one)

Married Single Divorced Spouse deceased

Do you or did you ever use alcohol? No___ Yes___ If yes, how much?______________________

Do you or did you ever smoke? No___ Yes___ If yes, when did you start?_____________________

How much do you smoke each day?_____________ If you quit, at what age?___________________

Do you use street drugs? No___ Yes___ If yes, type?_____________How frequently?___________

Are you on a special diet? No___ Yes___ If yes, please describe:_____________________________

Who gives your medication(s) Myself___ Other:____

FAMILY HISTORY

Does anyone in your family have any eye diseases? No___ Yes___ If so, what is their relationship to you and what type of eye disease do they have?

Relationship:_____________________________Condition:_________________________________
Relationship:_____________________________Condition:_________________________________
Relationship:_____________________________Condition:_________________________________
Relationship:_____________________________Condition:_________________________________

THANK YOU FOR YOUR HELP!

M.D. Initials:_____________