Valley EyeCare Center Medical Associates

Returning Patient History Questionnaire

Welcome back to our office!

First Name:	Last Name:	Date of Birth:
Home Phone Number:	Daytime Phone Number: □ same as home	Cell Number:
(Address, City, State and Zip Code):	any address change since your last visit? □ NO	Email address:

List all medications: □ None □ see list	Pharmacy name and location:
Allergies to medications: □ no known drug allergies	Primary Care Physician:
	Referred by:

Review of Systems:

General (fever, fatigue, weight loss)	□ No □ Yes	____
Cardiovascular (blood pressure, heart problems)	□ No □ Yes	____
Respiratory (Asthma, emphysema)	□ No □ Yes	____
Gastrointestinal (intestinal disease, stomach ulcer)	□ No □ Yes	____
Genital, Kidney, Bladder, Prostate	□ No □ Yes	____
Muscles, Joints, Bones (arthritis, pains)	□ No □ Yes	____
Integumentary (Skin) (acne, warts, skin cancer)	□ No □ Yes	____
Neurological (strokes, brain tumors, multiple sclerosis)	□ No □ Yes	____
Psychiatric (anxiety, depression, insomnia)	□ No □ Yes	____
Endocrine (diabetes, thyroid)	□ No □ Yes	____
Blood/Lymphatics (anemia, bleeding problems)	□ No □ Yes	____
Do you have AIDS or HIV?	□ No □ Yes	Date of Diagnosis ________________________
Are you pregnant or breastfeeding?	□ No □ Yes	____

Social History:

Do you use tobacco products? □ No □ Yes If yes, how long? _______ Do you drink alcohol? □ No □ Yes How often?________

Family History: Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, stroke, macular degeneration, glaucoma, cataract, retinal detachment, blindness)? □ No □ Yes

(details)____

History and ROS reviewed

Patient's Sig: ____________________ Date:_________	Doctor's Sig: ___________________Date:___________
Patient's Sig: ____________________ Date:_________	Doctor 's Sig: __________________ Date:___________
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