FLORIDA EYE INSTITUTE

fleye.com

MEDICAL HISTORY QUESTIONAIRE UPDATE

NAME: _____ DATE: _____
PHONE: _____ EMAIL: _____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: ☐ Cataract ☐ Glaucoma ☐ Dry Eye ☐ Blurred Vision ☐ Diabetes ☐ Macular Degeneration ☐ Other _____

Do you presently have any problems in the following areas? If "YES", please give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Itching, burning, or discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Gritty feeling, dryness or tearing	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, Nose, Mouth, Throat	[ ]	[ ]	_____
Cardiovascular (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones, glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal Allergies (hay fever, etc.)	[ ]	[ ]	_____

CHANGES IN HISTORY, MEDICATIONS, ALLERGY SINCE LAST VISIT

New Medical Diagnosis	[ ]	[ ]	_____
New Allergies	[ ]	[ ]	_____
New Medication(s) Medical	[ ]	[ ]	_____
New Medication(s) Eye	[ ]	[ ]	_____
Recent Eye Surgery	[ ]	[ ]	_____
New Eye Diagnosis	[ ]	[ ]	_____
New Family History	[ ]	[ ]	_____

REFRACTION FEE: Refraction is the measurement of glasses prescription for the purpose of prescribing new glasses or determining the best-corrected visual potential of the eye. Medicare and many private medical insurance programs do not cover this service and require a separate charge apart from the medical part of the exam. Some supplemental insurance will reimburse this fee. You will need to contact your insurance company to find out if and how they cover this service. You will be given a receipt if this service is performed**. REFRACTION FEE IS $40.**

Patient's Signature: _____ Date: _____

History reviewed [ ] No Changes [ ] Additions as noted
Technician Initials: _____ Physician's Signature: _____ Date: _____

Revised 3.9.2020