Progressive Vision Group, P.A.

● Joseph N. Perez, Jr., O.D. ● Staci A. Palmer, O.D. ●

Medical History Questionnaire

Last Name First Name M.I. Birth Date Today's Date

Primary Physician____________________________City____________________________State________

Previous Eye Doctor____________________________Date of Last Exam__________________________

Review of Symptoms
Are you currently experiencing any of the following?

Eyes	**Yes**		**Yes**		**Yes**
Blurred vision	☐	Drooping eyelid	☐	**Respiratory (lungs/breathing)**	☐
Tired eyes/eye strain	☐	Fluctuating visual acuity	☐	Chronic bronchitis	☐
Eye pain or soreness	☐	Lazy/crossed eye	☐	Asthma	☐
Glare/light sensitivity	☐	Glaucoma	☐	**Genitourinary (genital/kidney/bladder)**	☐
Headaches	☐	Cataracts	☐	**Gastrointestinal (stomach/intestines)**	☐
Poor night vision/glare	☐	Macular degeneration	☐	**Integument (skin and/or breast)**	☐
Double vision	☐	**Constitutional**	☐	**Musculoskeletal**	☐
Loss of vision	☐	Cancer ________________	☐	Arthritis	☐
Distorted vision (halos)	☐	Fever	☐	Fibromyalgia	☐
Redness	☐	Weight loss	☐	Osteoporosis	☐
Burning	☐	**Ear, nose, mouth, throat**	☐	**Endocrine**	☐
Itching	☐	Sinus issues	☐	Diabetes: Type 1 Type 2 *(circle one)*	☐
Excess tearing/watering	☐	Dry throat/mouth	☐	Thyroid disease: Hyper Hypo *(circle one)*	☐
Occasional tearing	☐	Hearing loss	☐	**Hematological/Lymphatics**	☐
Discharge	☐	**Psychiatric**	☐	Blood	☐
Foreign body sensation	☐	**Neurological**	☐	Lymph nodes	☐
Sandy or gritty feeling	☐	Migraine	☐	**Allergies and Immunologic**	☐
Dryness	☐	Stroke	☐	Latex allergy	☐
Infection of eye/lid	☐	Multiple sclerosis	☐	Seasonal allergies	☐
Styes, chalazion	☐	**Cardiovascular**	☐	Rheumatoid arthritis	☐
Iritis/Uveitis	☐	High blood pressure	☐	Sjogren's syndrome	☐
Floaters/Flashes of light	☐	High cholesterol	☐	**Other**________________________________	

Patient History
Are you on any medications? Yes No List any medications you currently take and dosages:

____

____

____

____

Do you have any medication allergies: Yes No

List any: ____

____

List any major illnesses and injuries and surgeries: ____

____

Current Height__________________Current Weight___________________Last Blood Pressure____________________

Social History	**Yes/No**	
Do you currently wear contacts?	☐ ☐	
Are you interested in trying contacts?	☐ ☐	
Do you currently wear glasses?	☐ ☐	How long have you had your current pair?___________
Have you ever considered Lasik?	☐ ☐	
Do you drink alcohol?	☐ ☐	
Do you smoke?	☐ ☐	Former?___________
Do you use a computer?	☐ ☐	
If YES, how many hours per day_____________		per week_________________
Have you ever had a blood transfusion?	☐ ☐	
Have you ever tested positive for tuberculosis?	☐ ☐	
Do you have an STD?	☐ ☐	
Are you currently pregnant or breastfeeding?	☐ ☐	

Family History

Diseases	**Family Member** *(mother, father, grandparent, siblings, aunt, uncle)*
Cancer	____
Diabetes Type 1	____
Diabetes Type 2	____
Hypertension	____
Hyperthyroidism	____
Hypothyroidism	____
Stroke	____
Tuberculosis	____
Cataract	____
Macular degeneration	____
Glaucoma	____
Other	____

I have reviewed the above information and verify that it is correct. I authorize Progressive Vision Group to release any information required to process my insurance claims. I further understand and acknowledge that it is my responsibility to inform this office of any changes in medical history.

Patient Name:____

Patient/Guardian Signature:____

Today's Date:_____/_____/________