MANDELL RETINA CENTER

Medical Questionnaire

Name _____ **Date** _____

Do you have or have had any of the following medical condition?

	Circle	Year diagnosed?	Circle Family history
Diabetes	**Yes or No**		Mother father sister brother grandparent
High blood pressure	**Yes or No**		Mother father sister brother grandparent
Heart Condition	**Yes or No**		Mother father sister brother grandparent
Stroke	**Yes or No**		Mother father sister brother grandparent
Cancer	**Yes or No**		Mother father sister brother grandparent
HIV	**Yes or No**		Mother father sister brother grandparent
Sickle cell anemia	**Yes or No**		Mother father sister brother grandparent
Asthma	**Yes or No**		Mother father sister brother grandparent
Lung disease	**Yes or No**		Mother father sister brother grandparent
Arthritis	**Yes or No**		Mother father sister brother grandparent
Bladder or prostate	**Yes or No**		Mother father sister brother grandparent
Elevated Cholesterol	**Yes or No**		Mother father sister brother grandparent
Thyroid	**Yes or No**		Mother father sister brother grandparent
Kidney disease	**Yes or No**		Mother father sister brother grandparent
Ulcers	**Yes or No**		Mother father sister brother grandparent
Skin Disease	**Yes or No**		Mother father sister brother grandparent
Hematologic	**Yes or No**		Mother father sister brother grandparent
Cataracts	**Yes or No**		Mother father sister brother grandparent
Glaucoma	**Yes or No**		Mother father sister brother grandparent
Eye Disease	**Yes or No**		Mother father sister brother grandparent

Have you had any eye operations? If so, list_____

_____

Do you smoke? **Yes or NO** **How much?**_____

Do you exercise regularly? **Yes or NO** **How often?** _____

Do you drink alcohol? **Yes or NO** **How often?** _____

Medication Allergies:_____

_____

_____

MANDELL RETINA CENTER

Review of Systems

Name _____ **Date** _____

Do you have or have had any of the following medical condition?

Review of Systems	**Do you have or have you recently experienced any of the following?**	**Circle**
Constitutional	Fever or Chills	**Yes or No**
	Weight gain or weight loss	**Yes or No**
Ear / Nose / Throat	Difficulty swallowing	**Yes or No**
	Swelling of your tongue	**Yes or No**
Nervous System	Have you ever passed out or lost consciousness?	**Yes or No**
	Numbness or tingling in your arms, hands, or feet	**Yes or No**
	Headaches, slurred speech, problems with swallowing	**Yes or No**
Cardiovascular	Chest Pain	**Yes or No**
	Swelling in your ankles, feet	**Yes or No**
	Hear skipping/pounding	**Yes or No**
Respiratory	Shortness of breath	**Yes or No**
	Wheezing	**Yes or No**
	Coughing up blood	**Yes or No**
Hematologic/Lymphatic	Painful or enlarged glands	**Yes or No**
	Easy bruising or easy bleeding	**Yes or No**
Gastrointestinal	Constipation, diarrhea, or bloody stools	**Yes or No**
	Nausea or Vomiting	**Yes or No**
	Do you have a history of ulcers?	**Yes or No**
Genitourinary	Trouble initiating urination	**Yes or No**
	Frequent urination	**Yes or No**
Musculoskeletal	Joint aches, joint swelling, muscle aches, lower back pain	**Yes or No**
Skin	Skin rashes	**Yes or No**
Psychiatric	Do you have a history of depression or other psychiatric illness	**Yes or No**

Patient Certification

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ Or _____ _____/____ /_____

Patient signature **Person authorized to sign and relationship to patient** **Date**

For office use only

Above reviewed by:

MANDELL RETINA CENTER

Medical Questionnaire

Patient Name___________________________________ **Date**_________________

Current Medications

Name of medication	Dosage	Route	Date Tech							