Mulqueeny Eye Centers

_____ _____/_____/_____
Patient Name Date of Birth

Do you have now, or have you ever had:
(Please circle any that apply to you)

PROBLEM

- ☐ Decreased Hearing
- ☐ Cancer
  - Type _____
  - Treatments_____
- ☐ Angina
- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Murmur
- ☐ Thrombophlebitis
- ☐ Varicose Veins
- ☐ Congestive Heart Failure
- ☐ Raynaud's Disease

- ☐ COPD
- ☐ Asthma
- ☐ TB
- ☐ Chronic Bronchitis
- ☐ Sarcoidosis

- ☐ Rosacea
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Poison Ivy
- ☐ Shingles
  - Affected Area _____
- ☐ Eczema
- ☐ Blepharitis

- ☐ Hemorrhoids
- ☐ Chron's Disease
- ☐ Colitis
- ☐ G.I. Cancer
- ☐ Ulcer
- ☐ Hiatus Hernia

- ☐ BPH
- ☐ Enlarged Prostate
- ☐ Frequent UTIs
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Renal Cancer

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Goiter
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

PROBLEM

- ☐ Alzheimer's
- ☐ Epilepsy
- ☐ Headaches
- ☐ Migraines
- ☐ MS
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Stroke
- ☐ TIAs
- ☐ Tremor
- ☐ Brain Tumor
- ☐ TBI
- ☐ Bell's Palsy

- ☐ Depression
- ☐ Mania
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Past Suicide Attempts

- ☐ Anemia
- ☐ Lymphoma Leukemia
- ☐ Hemophilia
- ☐ Factor Deficiency Disease

- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Lyme Disease
- ☐ Muscular Dystrophy
- ☐ Polymyalgia Rheumatica
- ☐ Fibromyalgia

Social History

Do you smoke?
☐ Yes ☐ No
Do you drink alcohol?
☐ Yes ☐ No
Do you drive?
☐ Yes ☐ No
Do you live alone?
☐ Yes ☐ No

Have you had a Pneumococcal Shot? ☐ Yes ☐ No

Do you have an Advanced Care plan? ☐ Yes ☐ No

Are you pregnant or nursing?
☐ Yes ☐ No

Are there any other health issues we should be aware of? _____
_____
_____
_____

Are you allergic to anything that you know of?
Yes _ No
If yes, please list, _____
_____
_____
_____

Please list all medications you take on a daily basis

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any **personal or family history** of any of the following;

	Self	**Family Relation**
Glaucoma	☐	☐ _____
Macular Degeneration	☐	☐ _____
Diabetes	☐	☐ _____
Retinal Disease	☐	☐ _____
Lazy Eye (or Eye Turn)	☐	☐ _____
Blindness	☐	☐ _____
Color Blind	☐	☐ _____
Light Sensitivity	☐	☐ _____
Dry Eyes	☐	☐ _____
Floaters	☐	☐ _____
Eye Injury	☐	☐ _____