CONEJO-SIMI EYE MEDICAL GROUP

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□ 2045 Royal Ave, Suite 125, Simi Valley, CA 93065 (805)527-6720 Fax (805)527-1889
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New Patient Medical History Questionnaire

Name _____ Date of birth _____ Today's Date _____

Date of your last eye exam _____ With whom? _____

List any medications you currently take (prescription and over-the-counter) _____

_____

Do you have allergies to any medications? No Yes If "yes," list the medications _____

_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) and/or injuries (concussion, etc.)

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____

_____

Do you currently have any problem in the following areas? If "yes," please provide details.			
Condition	**No**	**Yes**	**Details**
Eyes			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eye; lazy eye			
Drooping eyelid			
General/Constitution: Fever, weight loss, other			
Ears/Nose/Throat: Stuffy nose, earache, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, racing pulse, etc.			
Respiratory: Congestion, wheezing, asthma, etc.			

-Please complete side 2-

Conditions	No	Yes	Details
Genital/Kidney/Bladder: Painful urination, frequent urination, impotence, etc.			
Muscles/Bones/Joints: Joint pain, stiffness, swelling, cramps, etc.			
Skin: Pimples, warts, growths, rash, etc.			
Neurological: Numbness, headache, etc.			
Psychiatric: Anxiety, depression, insomnia			
Endocrine: Diabetes, hypothyroid, etc.			
Blood/Lymph: Cholesterolemia, anemia, etc.			
Allergic/Immunologic: Sneezing, swelling, redness, itching, hives, etc.			

Family History							
Condition	**No**	**Yes**		**Mother**	**Father**	**Sibling**	**Grand-parent**
Blindness							
Glaucoma							
Arthritis							
Cancer							
Diabetes							
Heart Disease or high blood pressure							
Kidney disease							
Lupus							
Stroke							
Thyroid disease							
Other:							

Social History

Current occupation: _____

Education: [ ] Preschool [ ] Elementary [ ] High school [ ] College Other _____

Marital Statues: [ ] Married [ ] Widowed [ ] Single [ ] Child

Living Arrangement: [ ] Own home [ ] With child(ren) [ ] Retirement home [ ] Assisted Living

Do you drive? No Yes

Do you have visual difficulty when driving? No Yes

Do you have problems with night vision? No Yes

Have you ever tried to wear contact lenses? No Yes

Do you currently wear contact lenses? No Yes If "yes," how long? _____

Do you currently wear glasses? No Yes If "yes," how old is your prescription? _____

Have you ever had a blood transfusion? No Yes

Do you drink alcohol? No Yes If "yes," Occasionally 1/day 2-3/day 4+/day

Do you smoke? No Yes If "yes," Occasionally ½pk/day 1pk/day 1+pk/day

Doctor's Signature _____ **Date** _____

- □ **Daniel Ebroon,M.D.**
- □ **John P. Fang, M.D.**
- □ **John Davidson, M.D.**
- □ **Ashish Toor, M.D.**
- □ **Joel Corwin, M.D.**
- □ **Shayna Mangers, M.D**
- □ **Andrew Young, M.D.**
- □ **Xiaolin Zhang, M.D.**
- □ **Jaspinder Kalra, O.D.**
- □ **Benica Eyvazzadeh, O.D.**
- □ **David I Halpert, O.D.**