ROBERT E. COOPER, OPTOMETRIST, INC.

Medical History Questionnaire

PATIENT REVIEW	
DATE	INITIAL

Today's Date:_____ Name:_____

Male ❑ Female ❑ I prefer to be called _____

Birthday ____/____/____ Age: _____ SS # _____ Marital Status _____

Home Address_____ City _____ State____ Zip_____

Home Phone #_____ Cell # _____

Employer_____ Occupation _____ Work #_____

Whom may we thank for referring you?_____

Other family members seen by us: _____

Personal Physician:_____ Date my eyes were last dilated: ____/____/____ Date of my last eye exam: ____/____/____

Email Address_____ Were you a premature baby? ❑ Yes ❑ No

MEDICAL INSURANCE	VISION INSURANCE
Primary Insurance_____	Primary Insurance_____
Insured Name_____	Insured Name_____
Member ID #_____	Member ID #_____
Secondary Insurance _____	Secondary Insurance _____
Insured Name_____	Insured Name_____
Member ID # _____	Member ID # _____

CURRENT MEDICATIONS W/ DOSAGE(ESP. PLAQUENIL, DIABETIC, HBP, CHOLESTEROL, GLAUCOMA, THYROID)

MAJOR HEALTH EVENTS, HOSPITALIZATIONS, & SURGERIES

DRUG ALLERGIES & OTHER KNOWN ALLERGIES (I.E. SHELLFISH, PEANUTS, SEASONAL)

ONGOING MEDICAL PROBLEMS

FAMILY MEDICAL HISTORY (ESP. MACULAR DEGENERATION, GLAUCOMA, HBP, HEART DISEASE, HIGH CHOLESTEROL, DIABETES, CANCER, THYROID)

PREVENTATIVE CARE/THERAPY CURRENTLY USING

SOCIAL HISTORY (ARE YOU A FORMER OR CURRENT SMOKER? HOW MUCH? ALCOHOL CONSUMPTION, RECREATIONAL DRUGS, ETC.)

NUTRITION HISTORY (DO YOU TAKE SUPPLEMENTS, HAVE SPECIAL DIETARY NEEDS)

DEVELOPMENTAL HISTORY(WERE YOU PREMATURE, MAJOR CHILDHOOD INJURY)

RACE AND PREFERRED LANGUAGE

HEIGHT & WEIGHT