Scott L. Rosen M.D.
Amy L. Cunningham M.D.
Eye Physicians and Surgeons

MEDICAL HISTORY QUESTIONAIRE

Patient Name: _____ **Date of Birth:** _____

MEDICAL HISTORY: *(please check)*

Diabetes ___	Heart Disease___	Stroke ___	High Cholesterol ___
Thyroid ___	Hypertension ___	Asthma___	Neurological ___
Skin Disease___	Cancer___	Migraine___	Arthritis ___
Kidney Disease___	Colitis ___		

Explain (*surgeries, duration, and level of control):*_____
_____
_____

EYE HISTORY: *(please list surgery and dates if applicable)*
Cataracts: _____
Macular Degeneration: _____
Amblyopia: _____
Retinal surgery/laser: _____
LASIK/Refractive surgery: _____

SYSTEMS REVIEW: *(circle)*

Depression	Weakness	Diarrhea	Fatigue	Chronic Cough
Pain	Anxiety	Headache	Joint Pain	Gastric Reflux
Urinary	Hearing Loss	Weight Gain	Weight Loss	Ankle Swelling
Chest Pain	Palpitations	Shortness of Breath		

FAMILY HISTORY: *(circle)*
Glaucoma Cataracts Macular Degeneration Retinal Detachment Amblyopia
Explain: _____
_____

SOCIAL HISTORY:
Tobacco Y/N Alcohol Y/N Driving Y/N Occupation: _____
Hobbies: _____

ALLERGIES: _____

MEDICATIONS: _____
_____
_____

PATIENT SIGNATURE: _____

Date: _____ **Reviewed by:** _____

Scott L. Rosen M.D. Amy L. Cunningham M.D.
Eye Physicians and Surgeons

Patient Name: _____Date: _____

Social Security Number: _ _ _ - _ _ - _ _ _ _ Date of Birth: ____ / ____ / _____
MM DD YEAR

Sex: M / F (circle one) Marital Status: _____

Address: _____
STREET CITY STATE ZIP CODE

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____ Other Phone: ( ) _____ - _____

Emergency Contact Info:

Name: _____ Relationship: _____

Phone: ( ) _____ - _____ 2nd Phone: ( ) _____ - _____

Primary Physician: _____

Referring Physician: _____

How did you hear about us? _____

Guarantor Information (person responsible for balance after insurance):

Name: _____ Phone: ( ) _____ - _____

Address: _____
STREET CITY STATE ZIP CODE

Date of Birth: ____ / ____ / _____
MM DD YEAR

Payment Policy

Office co-payments are to be paid at time of service. I understand that I am ultimately responsible for all charges/services rendered. I authorize Scott Rosen, M.D. LTD to bill and release to my insurance company any medical information necessary to process claims.

Signature: _____ Date: _____
(Patient or authorized representative)