KIM-BINH MAI, MD
VITREORETINAL SURGERY AND DISEASES

Patient's full name: **Date:**

MEDICAL HISTORY QUESTIONNAIRE

The Health Care Financing Administration requires we obtain the following information from you to be in compliance with their patient history guidelines for billing consultation services. If you have any questions regarding this form or need assistance, please let our staff know.

What symptoms or complaints do you have with your vision (please be specific, including dates)?

List all major illnesses and injuries that you have had in the past:

List any surgeries (including on your eyes) that you have had in the past:

List any medications (including any eye medications) that you take:

List any allergies you have (including medication allergies):

Do you presently have any problems with the following areas?

Integument (skin)	☐ YES ☐ No	☐ YES ☐ No	Neurological
Ears, Nose, Mouth, Throat	☐ YES ☐ No	☐ YES ☐ No	Lymph Nodes
Respiratory (lungs)	☐ YES ☐ No	☐ YES ☐ No	Hematopoietic (blood)
Cardiovascular (heart)	☐ YES ☐ No	☐ YES ☐ No	Allergic / Immunologic
Gastrointestinal (stomach)	☐ YES ☐ No	☐ YES ☐ No	Genitourinary
Bones, Joints, Muscles	☐ YES ☐ No		

Do you drink alcohol? ☐ YES ☐ No

Do you smoke? ☐ YES ☐ No

Are you taking blood thinners? ☐ YES ☐ No If yes, what are you taking? _____

Do you think you may have been exposed to HIV? ☐ YES ☐ No

_____

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Patient/Guardian Signature