MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted) □ Amblyopia (Lazy eye)
□ Diabetic Retinopathy □ Iritis □ Optic Neuritis □ Aphakia
□ Dry Eyes □ Keratoconus □ Retinal Detachment □ Astigmatism
□ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**	**R - L**
□ □ Foreign Body Removal	□ □ Punctal Plugs	□ □ Laser	□ □ Cataract Surgery
□ □ Blepharoplasty	□ □ Retinal Laser Surgery	□ □ RK	□ □ LASIK
□ □ Strabismus Surgery	□ □ Vitrectomy	□ □ Corneal Transplant	□ □ PRK (eye muscle surgery)

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Other Medical History: □ No history of illnesses

□ Thyroid Disease □ Congestive Heart Failure □ Headache □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes Type 1 □ High Cholesterol □ Migraine
□ Arrhythmia □ Diabetes Type 2 □ HIV/ AIDS □ Polymyalgia
□ Asthma □ Eczema □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Fibromyalgia □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Chicken Pox □ Herpes Zoster / Shingles □ Meningitis □ Toxoplasmosis
□ Hepatitis A / B / C □ Histoplasmosis □ MRSA □ Wound Infection
□ Herpes Simplex □ Syphillis

Other_____

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure