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)

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

Other____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other____

Current Eye Medications: (Please list)

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Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other____

General Surgeries / Operations: (Please list)

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Current Other Medications: (Please list)

____

____

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Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other____

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?____

Personal History:

Are you pregnant? □ Yes □ No □ Maybe

Have you had the pneumonia vaccine? □ Yes □ No If yes, approximate date ______________________________

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