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 □ Other ________________

Ethnicity: □ Hispanic □ Not Hispanic

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

□ Russian □ Spanish □ Vietnamese □ Polish □ Other __________________

Allergies: Reaction Severity

__________________________ _______________________________ mild / moderate / severe

__________________________ _______________________________ mild / moderate / severe

__________________________ _______________________________ mild / moderate / severe

__________________________ _______________________________ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ None

□ 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 (eye muscle surgery)
□ Punctal Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other____

Ocular Significant Illnesses: (Please mark all that apply)

□ None

□ 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)

□ None

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

Other____

Family History:

□ None

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

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

- □ None
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat

- □ None
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular

- □ None
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional

- □ None
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory

- □ None
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal

- □ None
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary

- □ None
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric

- □ None
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine

- □ None
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes

- □ None
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal

- □ None
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin

- □ None
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological

- □ None
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic

- □ None
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Thank you for your continued support and patience as we transition to electronic medical records.