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

Past Ocular History: (Please mark all that apply)

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

Other____

Ocular Surgeries: (Please mark all that apply)

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

Other____

Current Eye Medications: (Please list)

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Past Medical History:

No history of illnesses	Congestive Heart Failure	Hepatitis	Lung Disease
Aids	COPD	Herpes	Lupus
Anemia	Diabetes	High Blood Pressure	Migraine
Arthritis	Eczema	High Cholesterol	Multiple Sclerosis
Arrhythmia	Fibromyalgia	HIV Positive	Polymyalgia
Asthma	Headache	Infections-Type_____________	Psychiatric Disorder
Bleeding Disorder	Hearing Loss	Kidney Disease	Rheumatoid Arthritis
Cancer-Type____________	Heart Attack	Liver Disease	Stroke

Other____

General Surgeries / Operations: (Please list)

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Current Medications: (Please list)

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Family History:

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?____

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