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
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Blepharitis
□ 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
□ Laser Retinal Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery (Eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other_____

Current Eye Medications: (Please list)

_____

_____

_____

Past Medical History:

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

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Current 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?_____

Please mark all that apply to you:

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