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/PRK
◻ ◻ Strabismus Surgery	◻ ◻ Vitrectomy	◻ ◻ Corneal Transplant	◻ ◻ Eye Muscle Surgery

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Are you currently pregnant? Yes_____ No_____

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

Eyes *

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Ear, Nose, and Throat *

Hard of Hearing	☐ YES	☐ NO
Ringing in Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Cardiovascular *

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Constitutional *

Fatigue/Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain/Loss	☐ YES	☐ NO

Respiratory *

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Gastrointestinal *

Heartburn	☐ YES	☐ NO
Nausea/Vomiting	☐ YES	☐ NO
Jaundice/Hepatitis	☐ YES	☐ NO

Genito-Urinary *

Pain/Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Psychiatric *

Anxiety/Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Endocrine *

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Blood/Lymphnodes *

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Aspirin Use	☐ YES	☐ NO

MusculoSkeletal *

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain/Swelling	☐ YES	☐ NO
More than 2 falls in last y	☐ YES	☐ NO

Skin *

Rash/Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives/Eczema	☐ YES	☐ NO

Neurological *

Seizures	☐ YES	☐ NO
Weakness/Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Immunologic *

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO
Influenza vaccination?	☐ YES	☐ NO
Pneumonia vaccination?	☐ YES	☐ NO