MEDICAL HISTORY QUESTIONNAIRE

_____ _____
PATIENT NAME **DATE**

❑ Male ❑ Female Date of Birth ____/____/_____

Primary Care Physician _____

Referring/Specialty Dr. _____

Pharmacy _____ Phone Number_____

Location _____

RACE ❑ American Indian or Alaska Native ❑ Black or African American
❑ Asian ❑ White ❑ Native Hawaiian or Other Pacific Islander

ETHNICITY ❑ Hispanic ❑ Not Hispanic

PREFERRED LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Italian
❑ Japanese ❑ Portuguese ❑ Russian

DRUG ALLERGIES ❑ None	**REACTION**	**SEVERITY**
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe

PAST OCULAR HISTORY ❑ No history of eye problems
(Mark all that apply)

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

Other_____

_____

_____

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OCULAR SURGERIES ❑ No prior ocular surgery
(Mark all that apply)

R - L	R - L	R - L	R - L
❑ ❑ Foreign Body Removal	❑ ❑ Punctal Plugs	❑ ❑ Laser	❑ ❑ Cataract Surgery
❑ ❑ Blepharoplasty	❑ ❑ Retinal Laser Surgery	❑ ❑ RK	❑ ❑ LASIK
❑ ❑ Strabismus Surgery	❑ ❑ Corneal Transplant	❑ ❑ Vitrectomy	❑ ❑ PRK

Other_____

CURRENT EYE MEDICATIONS (Please list all)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OTHER MEDICAL HISTORY ❑ No history of illnesses

❑ Anemia	❑ Diabetes Type 2	❑ High Blood Pressure	❑ Migraine
❑ Arthritis	❑ Eczema	❑ High Cholesterol	❑ Polymyalgia
❑ Arrhythmia	❑ Fibromyalgia	❑ HIV / AIDS	❑ Psychiatric Disorder
❑ Asthma	❑ Hepatitis A/B/C	❑ Kidney Disease	❑ Skin Cancer
❑ Bleeding Disorder	❑ Herpes Simplex	❑ Kidney Stones	❑ Stroke
❑ Cancer	❑ Hearing Loss	❑ Liver Disease	❑ Thyroid Disease
❑ Congestive Heart Failure	❑ Herpes Zoster/Shingles	❑ Meningitis	❑ Toxoplasmosis
❑ COPD	❑ Histoplasmosis	❑ MRSA	❑ Wound Infection
❑ Dementia/Alzheimer's	❑ Syphillis	❑ Lung Disease	
❑ Diabetes Type 1	❑ Headache	❑ Lupus	

Other_____

GENERAL SURGERIES / OPERATIONS (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALL OTHER MEDICATIONS ❑ None

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY AND RELATIONSHIP (Father, Mother, Maternal Grandparent, Paternal Grandparent, etc)

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

Other_____

SOCIAL HISTORY
(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
(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
❑ Hypertension

CONSTITUTIONAL
❑ Fatigue / Weakness
❑ Fever
❑ Weight Gain / Loss
❑ Headaches

RESPIRATORY
❑ Cough
❑ Congestion
❑ Wheezing
❑ Asthma
❑ Seasonal Allergies

GASTROINTESTINAL
❑ Heartburn
❑ Nausea / Vomiting
❑ Jaundice / Hepatitus
❑ Diarrhea

GENITO-URINARY
❑ Pain / Difficulty
❑ Blood in Urine
❑ History of Kidney Stones
❑ History of STD's

PSYCHIATRIC
❑ Anxiety / Depression
❑ Mood Swings
❑ Difficulty Sleeping
❑ Mental Illness

ENDOCRINE
❑ Increased Thirst
❑ Increased Hunger
❑ Increased Urination
❑ Increased Sweating
❑ Fingernail Changes
❑ Diabetes
❑ Thyroid

BLOOD / LYMPHNODES
❑ Easy Bruising
❑ Gums Bleed Easy
❑ Prolonged Bleeding
❑ Heavy Aspirin Use
❑ Anemia
❑ Sickle Cell

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