Eye Center of Texas
Leaders in Eye Care

MEDICAL HISTORY QUESTIONNAIRE

NAME _____ Date of Birth ____/____/____

Primary Care Physician _____ Referring/Specialty Dr. _____

Pharmacy _____ Location _____ _____
STREET CITY

RACE

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

ETHNICITY ❑ Hispanic ❑ Not Hispanic

PREFERRED LANGUAGE

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

DRUG 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
❑ ❑ Strabismus Surgery	❑ ❑ Corneal Transplant	❑ ❑ Vitrectomy	❑ ❑ PRK

Other _____

CURRENT EYE MEDICATIONS (PLEASE LIST)

OTHER MEDICAL HISTORY ❑ No history of illnesses

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

Other _____

GENERAL SURGERIES / OPERATIONS (PLEASE LIST)

ALL OTHER MEDICATIONS

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

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