

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

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hyperopia (Far sighted)	<input type="checkbox"/> Myopia (Near sighted)	<input type="checkbox"/> Amblyopia (Lazy eye)
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Iritis	<input type="checkbox"/> Optic Neuritis	<input type="checkbox"/> Aphakia
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Astigmatism
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration		

Other _____

Ocular Surgeries: (Please mark all that apply) No prior ocular surgery

R - L	R - L	R - L	R - L
<input type="checkbox"/> Foreign Body Removal	<input type="checkbox"/> Punctal Plugs	<input type="checkbox"/> Laser	<input type="checkbox"/> Cataract Surgery
<input type="checkbox"/> Blepharoplasty	<input type="checkbox"/> Retinal Laser Surgery	<input type="checkbox"/> RK	<input type="checkbox"/> LASIK
<input type="checkbox"/> Strabismus Surgery	<input type="checkbox"/> Vitrectomy	<input type="checkbox"/> Corneal Transplant	<input type="checkbox"/> PRK (eye muscle surgery)

Other _____

Current Eye Medications: (Please list)

Other Medical History: No history of illnesses

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

Other _____

General Surgeries / Operations: (Please list)

All Other Medications: (Please list)

Family History:

- | | | | |
|------------------------------------|--|---|---------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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? _____

Review of Systems: (Please mark all that apply)

- | | | |
|--|---|--|
| Eyes <ul style="list-style-type: none"><input type="checkbox"/> Previous Surgery<input type="checkbox"/> Contact Lens<input type="checkbox"/> Pain<input type="checkbox"/> Double Vision<input type="checkbox"/> Glaucoma<input type="checkbox"/> Cataracts<input type="checkbox"/> Macular Degeneration<input type="checkbox"/> Dry Eyes<input type="checkbox"/> Flashes<input type="checkbox"/> Floaters | Respiratory <ul style="list-style-type: none"><input type="checkbox"/> Cough<input type="checkbox"/> Congestion<input type="checkbox"/> Wheezing<input type="checkbox"/> Asthma | Blood / Lymphnodes <ul style="list-style-type: none"><input type="checkbox"/> Easy Bruising<input type="checkbox"/> Gums Bleed Easy<input type="checkbox"/> Prolonged Bleeding<input type="checkbox"/> Heavy Aspirin Use |
| Ear, Nose, and Throat <ul style="list-style-type: none"><input type="checkbox"/> Hard of Hearing<input type="checkbox"/> Ringing in Ears<input type="checkbox"/> Vertigo | Gastrointestinal <ul style="list-style-type: none"><input type="checkbox"/> Heartburn<input type="checkbox"/> Nausea / Vomiting<input type="checkbox"/> Jaundice / Hepatitis | MusculoSkeletal <ul style="list-style-type: none"><input type="checkbox"/> Stiffness<input type="checkbox"/> Arthritis<input type="checkbox"/> Joint Pain / Swelling |
| Cardiovascular <ul style="list-style-type: none"><input type="checkbox"/> Chest Pain<input type="checkbox"/> Dizziness<input type="checkbox"/> Fainting Spells<input type="checkbox"/> Shortness of Breath<input type="checkbox"/> Irregular Heart Beat<input type="checkbox"/> Difficulty Lying Flat | Genito-Urinary <ul style="list-style-type: none"><input type="checkbox"/> Pain / Difficulty<input type="checkbox"/> Blood in Urine<input type="checkbox"/> History of Kidney Stones<input type="checkbox"/> History of STD's | Skin <ul style="list-style-type: none"><input type="checkbox"/> Rash / Sores<input type="checkbox"/> Lesions<input type="checkbox"/> Hives / Eczema |
| Constitutional <ul style="list-style-type: none"><input type="checkbox"/> Fatigue / Weakness<input type="checkbox"/> Fever<input type="checkbox"/> Weight Gain / Loss | Psychiatric <ul style="list-style-type: none"><input type="checkbox"/> Anxiety / Depression<input type="checkbox"/> Mood Swings<input type="checkbox"/> Difficulty Sleeping | Neurological <ul style="list-style-type: none"><input type="checkbox"/> Seizures<input type="checkbox"/> Weakness / Paralysis<input type="checkbox"/> Numbness<input type="checkbox"/> Tremors |
| | Endocrine <ul style="list-style-type: none"><input type="checkbox"/> Increased Thirst<input type="checkbox"/> Increased Hunger<input type="checkbox"/> Increased Urination<input type="checkbox"/> Increased Sweating<input type="checkbox"/> Fingernail Changes | Immunologic <ul style="list-style-type: none"><input type="checkbox"/> Hives<input type="checkbox"/> Itching<input type="checkbox"/> Runny Nose<input type="checkbox"/> Sinus Pressure |