

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)

Overall Healthy 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 Foreign Body Removal Punctal Plugs Trabeculectomy (Glaucoma)
 Blepharoplasty Retinal Laser Surgery RK Vitrectomy
 Cataract Surgery LASIK Strabismus Surgery
 Corneal Transplant PRK (eye muscle surgery)

Other _____

Ocular Significant Illnesses: (Please mark all that apply)

Overall Healthy Herpes Hypothyroidism Sjogrens
 AIDS HIV Positive Lupus Graves Disease
 Diabetes Hypertension Multiple Sclerosis
Hyperthyroidism
 Rheumatoid Arthritis

Other _____

Current Eye Medications: (Please list)

Systemic Illnesses:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> No history of illnesses | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <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 | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Eczema | <input type="checkbox"/> HIV | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric |
| Disorder | | | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headache | <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"/> Thyroid Disease | | | |

Other _____

General Surgeries / Operations: (Please list)

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Current Other Medications: (Please list)

Infections: (Please mark all that apply)

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Syphilis |
| <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 Infection | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Wound |

Other _____

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

- 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 / Hepatitis

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