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

Other _____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other _____

Ocular Significant Illnesses: (Please mark all that apply)

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

Other _____

Current Eye Medications: (Please list)

_____
_____
_____

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other _____

General Surgeries / Operations: (Please list)

_____
_____
_____

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Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

- ◻ Overall Healthy
- ◻ Chicken Pox
- ◻ Hepatitis A / B / C
- ◻ Herpes Simplex
- ◻ Herpes Zoster / Shingles
- ◻ Histoplasmosis
- ◻ HIV / AIDS
- ◻ Meningitis
- ◻ MRSA
- ◻ Syphillis
- ◻ Toxoplasmosis
- ◻ Wound Infection

Other_____

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: (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

Respiratory
- ◻ Cough
- ◻ Congestion
- ◻ Wheezing
- ◻ Asthma

Gastrointestinal
- ◻ Heartburn
- ◻ Nausea / Vomiting
- ◻ Jaundice / Hepatitus

Genito-Urinary
- ◻ Pain / Difficulty
- ◻ Blood in Urine
- ◻ History of Kidney Stones
- ◻ History of STD's

Psychiatric
- ◻ Anxiety / Depression
- ◻ Mood Swings
- ◻ Difficulty Sleeping

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