MEDICAL HISTORY QUESTIONNAIRE

Todays Date: ____/____/______

Name: ______________________________________ Nickname: ___________________________ Date of Birth: ____/____/______

Primary Care Physician: _________________________________ Referring /Specialty Dr._____________________________________

Pharmacy:____________________________________ Location(street & city) ____

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 / Date Performed: (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_______ (eye muscle surgery)
- □ Glaucoma_______ Laser/Surgery
- □ Vitrectomy_______

Other____

Current Eye Medications: (Please list)	Right / Left / Both Eyes	Times/Days
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________

Systemic Illnesses:

- □ No history of illnesses
- □ Anemia
- □ Arthritis (Osteo/Rheumatoid)
- □ Arrhythmia
- □ Asthma
- □ Bleeding Disorder
- □ Cancer – Type:____________
- □ Thyroid Disease
- □ Multiple Sclerosis
- □ Hyperthyroidism
- □ MRSA
- □ Congestive Heart Failure
- □ COPD
- □ Diabetes (Type 1/ Type 2)
- □ Eczema
- □ Fibromyalgia
- □ Headache
- □ Hearing Loss
- □ Herpes Simplex
- □ Sjogrens
- □ Chicken Pox
- □ Syphilis
- □ Hepatitis
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV/AIDS
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Hepatitis A / B / C
- □ Histoplasmosis
- □ Herpes Zoster / Shingles
- □ Toxoplasmosis
- □ Lung Disease
- □ Lupus
- □ Migraine
- □ Polymyalgia
- □ Psychiatric Disorder
- □ Wound Infection
- □ Stroke
- □ Hypothyroidism
- □ Graves Disease
- □ Meningitis

Other____ Are you currently pregnant: ☐ YES ☐ NO Due Date:_____________

General Surgeries / Operations: (Please list)

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Current Other Medications: (Please list)

Name	Dosage	Times/Day	Oral / Topical / Injection / etc

Family History / Relationship (mother, father, sibling, etc.) / Living or Deceased

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

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 to you TODAY)

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
- □ Sleep Apnea/CPAP

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

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