MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________________ Date of Birth: ____/____/______ Medical Record # ______________

Primary Care Physician _____________________________

Pharmacy:____________________________________ Location(street & city) ____

Medication 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 □ Optic Neuritis □ Macular Degeneration
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Glaucoma
□ Dry Eyes □ Keratoconus □ Retinal Detachment

Other____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Corneal Transplant □ PRK □ Vitrectomy
□ Blepharoplasty □ Retinal Laser Surgery □ RK
□ Cataract Surgery □ LASIK □ Strabismus Surgery (eye muscle surgery)

Other____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy □ Graves Disease □ Lupus □ Sjogrens
□ AIDS/HIV □ Herpes □ Multiple Sclerosis □ Thyroid Problems
□ Diabetes □ Hypertension □ Rheumatoid Arthritis

Other____

Current Eye Medications: (Please list)

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Systemic Illnesses:

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

Other____

General Surgeries / Operations: (Please list)

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Current Other Medications: (Please list)

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Infections: (Please mark all that apply)

□ Overall Healthy　□ Cold Sores　□ HIV / AIDS　□ Herpes Zoster / Shingles
□ Hepatitis A / B / C　□ Meningitis　□ MRSA

Other____

Family History and Relationship to Family Member:

□ Diabetes ______________________　□ Stroke ________________________　□ High Blood Pressure _____________
□ Glaucoma _____________________　□ Lazy Eye _______________________　□ Macular Degeneration ____________
□ Cancer _______________________　□ Heart Disease ___________________　□ Retinal Disease _________________

Social History: (Please mark all that apply)

Smoking:　□ current every 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 / 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
- □ Blood Thinners/Asprin

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching