MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/_____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Preferred Language: ❑ English ❑ French ❑ Spanish ❑ Russian ❑ Italian ❑ Other _____

HEALTHCARE PROVIDER INFORMATION:

Primary Care Physician: _____ Phone #: _____

Pharmacy Name and Location (street & city): _____

Drug Allergies:	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) ❑ No history of eye problems

❑ Amblyopia (Lazy Eye) ❑ Diabetic Retinopathy ❑ Iritis/Uveitis ❑ Retinal Detachment
❑ Astigmatism ❑ Dry Eye Syndrome ❑ Macular Degeneration
❑ Cataracts ❑ Glaucoma ❑ Myopia (Nearsighted)
❑ Corneal Disorder ❑ Hyperopia (Farsighted) ❑ Narrow Angle Glaucoma

Other _____

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

R - L	R - L	R - L
❑ Blepharoplasty (Lid Surgery)	❑ Glaucoma Surgery or Laser	❑ Strabismus (eye muscle surgery)
❑ Cataract Surgery	❑ Laser Retinal Surgery	❑ Vitrectomy
❑ Corneal Transplant	❑ LASIK	❑ AG Laser Capsulotomy

Other _____

Current Eye Medications: (Please list and include which eye and how frequent)

_____ _____ _____

_____ _____ _____

Past Medical History: ❑ No history of illnesses

❑ Anemia ❑ Headache ❑ Liver Disease ❑ Sleep Apnea
❑ Arthritis ❑ Hearing Loss ❑ Lupus ❑ Uses CPAP Machine
❑ Arrhythmia ❑ Heart Attack ❑ Migraine
❑ Asthma ❑ Hepatitis ❑ Multiple Sclerosis
❑ Cancer ❑ Herpes ❑ Polymyalgia Rheumatica
❑ Congestive Heart Failure ❑ High Blood Pressure ❑ Psychiatric Disorder
❑ COPD ❑ High Cholesterol ❑ Rheumatoid Arthritis
❑ Diabetes (circle: Type 1 or Type 2) ❑ HIV/AIDS ❑ Stroke
❑ Fibromyalgia ❑ Kidney Disease ❑ Thyroid Disease

Other _____

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Exam Date: _____

General Surgeries/Procedures: (Please list and give year)

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: (Please indicate relationship) ❑ No history of illnesses ❑ History unknown

❑ Blindness ❑ Glaucoma ❑ Macular Degeneration ❑ Migraines
❑ Cancer ❑ Heart Disease ❑ Retinal Disease ❑ Thyroid Disease
❑ Cataracts ❑ High Blood Pressure ❑ Stroke
❑ Diabetes ❑ Lazy Eye ❑ Other_____

Social History: (Please mark all that apply)

Smoking: ❑ current every day smoker ❑ current some day smoker ❑ former smoker ❑ never smoked

Alcohol Use: ❑ No ❑ Yes If yes, how much and how often? _____

Drug Use: ❑ No ❑ Yes If yes, which and how long? _____

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

Genitourinary
- ❑ 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/Lymph Nodes
- ❑ 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

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____