MEDICAL HISTORY QUESTIONNAIRE

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

Referring Doctor: _____ **Primary Care Physician:** _____

Pharmacy Name and Location (street & city): _____

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_____

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)
□ Astigmatism
□ Cataracts
□ Corneal Disorder
□ Diabetic Retinopathy
□ Dry Eye Syndrome
□ Glaucoma
□ Hyperopia (Farsighted)
□ Iritis/Uveitis
□ Macular Degeneration
□ Myopia (Nearsighted)
□ Retinal Detachment

Other_____

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

R - L	**R - L**	**R - L**
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery	□ □ Strabismus (eye muscle surgery)
□ □ Cataract Surgery	□ □ Laser Retinal Surgery	□ □ Vitrectomy
□ □ Corneal Transplant	□ □ LASIK	□ □ YAG Laser Capsulotomy

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Other Medical History: □ No history of illnesses

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

Other_____

General Surgeries/Procedures: (Please list)

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ 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 / Hepatitus

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:**_____