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) □ Diabetic Retinopathy □ Iritis/Uveitis
□ Astigmatism □ Dry Eye Syndrome □ Macular Degeneration
□ Cataracts □ Glaucoma □ Myopia (Nearsighted)
□ Corneal Disorder □ Hyperopia (Farsighted) □ 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 □ Headache □ Liver Disease
□ Arthritis □ Hearing Loss □ Lupus
□ 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_____

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 □ Glaucoma □ Macular Degeneration
□ Cancer □ Heart Disease □ Retinal 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 / 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:_____