MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth**: _____

Ethnicity	**Race**	
___ Hispanic	___ American-Indian / Alaska Native	
___ Not Hispanic	___ Asian	____Middle Eastern
Preferred Language	___ Black / African American	____Native Hawaiian or Other Pacific Islander
___ English	___ East Indian	____White
___ Spanish	___ Hispanic or Latino	____Other
___ Other:_____		

Allergies (drug, seasonal, environmental)	**Reaction (circle one)**	**None Known**
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	
	rash/ nausea/ shortness of breath / other	

Past Ocular History: (Please mark all that apply and indicate which eye)

____ Overall Healthy	____ Cataracts	____ Herpes	____ Macular Degeneration
____ Amblyopia (Lazy eye)	____ Diabetic Retinopathy	____ Hyperopia (Far sighted)	____ Myopia (Near sighted)
____ Aphakia	____ Dry Eyes	____ Iritis	____ Optic Neuritis
____ Astigmatism	____ Glaucoma	____ Keratoconus	____ Retinal Detachment

Past Ocular Surgeries: (Please mark all that apply and indicate which eye and dates)

____ No prior ocular surgery	____ Foreign Body Removal	____ PRK	____ Trabeculectomy (glaucoma)
____ Blepharoplasty	____ (Retinal) Laser Surgery	____ Punctal Plugs	____ Vitrectomy
____ Cataract Surgery	____ (Glaucoma) Laser Surg	____ RK	____ YAG Capsulotomy
____ Corneal Transplant	____ LASIK	____ Strabismus Surgery (eye muscle)	

Current EYE Medications: (Please list)

_____

_____

_____

Past Medical History:

____ No history of illness	____ COPD	____ High Cholesterol	____ MRSA
____ Anemia	____ Diabetes - Type I / II	____ HIV / AIDS	____ Polymyalgia
____ Arthritis	____ Eczema	____ Kidney Disease	____ Psychiatric Disorder
____ Arrhythmia	____ Fibromyalgia	____ Kidney Stones	____ Skin Cancer
____ Asthma	____ Headache	____ Liver Disease	____ Sjogrens
____ Bleeding Disorder	____ Hearing Loss	____ Lung Disease	____ Stroke
____ Cancer	____ Hepatitis A / B / C	____ Lupus	____ Syphillis
____ Chicken Pox	____ Herpes Zoster / Shingles	____ Migraine	____ Toxoplasmosis
____ Congestive Heart Failure	____ High Blood Pressure	____ Multiple Sclerosis	____ Wound Infection

Current Other Medications: (Please list)

_____

_____

_____

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Past Surgeries / Operations: (Please list)

_____

_____

_____

Family History: (siblings, parents, grandparents)

	Relationship	Living (circle one)		Relationship	Living (circle one)
____	Diabetes	Yes or No	____	Blindness	Yes or No
____	Cancer	Yes or No	____	Cataract	Yes or No
____	Heart Disease	Yes or No	____	Glaucoma	Yes or No
____	Stroke	Yes or No	____	Macular Degeneration	Yes or No
____	TB	Yes or No	____	Retinal Disease	Yes or No
____	Kidney Disease	Yes or No	____	High Blood Pressure	Yes or No
____	Arthritis	Yes or No	____	Lazy Eye	Yes or No
			____	Thyroid Disease	Yes or No

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 CURRENTLY 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 Easily
____ Prolonged Bleeding
____ Heavy Aspirin Use

MusculoSkeletal

____ Stiffness
____ Arthritis
____ Joint Pain / Swelling

Skin

____ Rash / Sores
____ Lesions
____ Hives / Eczema

Neurological

____ Seizures
____ Weakness / Paralysis
____ Numbness
____ Tremors

Immunologic

____ Itching
____ Runny Nose
____ Sinus Pressure

Other _____