MEDICAL HISTORY QUESTIONNAIRE Date _____

Birthday _____

Name: _____

Referring /Specialty Dr. _____

Primary Care Physician: _____

Pharmacy: _____ Location(street & city) _____

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

___ **No known drug allergies**

(Use back for any additional) ☐ Do you wear contact lenses?

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

☐ Amblyopia (Lazy eye)
☐ Aphakia
☐ Cataracts
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ Keratoconus
☐ Macular Degeneration
☐ Optic Neuritis
☐ Retinal Detachment
☐ Other _____

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

R - L	**Date**	**R - L**	**Date**	**R - L**	**Date**
☐ ☐ Foreign Body Removal	____	☐ ☐ Punctal Plugs	____	☐ ☐ Cataract Surgery	____
☐ ☐ Blepharoplasty	____	☐ ☐ Retinal Surgery	____	☐ ☐ RK	____
☐ ☐ LASIK	____	☐ ☐ PRK	____	☐ ☐ Strabismus Surgery	____
☐ ☐ Corneal Transplant	____	☐ ☐ Other Lasers	_____	☐ ☐ Other _____	

Current Eye Medications: (Please list dosage and frequency) Including over the counter.

_____ _____ _____

_____ _____ _____

Current Eye Conditions (Check all that apply) ☐ No current eye conditions

___ Blurred vision
___ Double vision
___ Mucous discharge
___ Sandy or gritty feeling
___ Distorted vision (things look crooked)
___ Eye pain or soreness
___ Flashing lights
___ Fluctuating vision
___ Dryness
___ Redness
___ ltching
___ Tired eyes, fatigue
___ lnfection of eye or lid lump
___ Loss of side vision
___ Glare/light sensitivity/halos
___ Eye trauma
___ Burning
___ Drooping eyelid
___ Excess tearing or watering
___ Floaters

Other _____

All Other Medications: (Please list dosage strength and frequency) ☐ None

_____ _____ _____

_____ _____ _____

Have you ever taken Flomax? ____ yes ____ no

Name: _____

Other Medical History: ☐ No history of illnesses

☐ Alzheimer's	☐ Anemia	☐ Arrhythmia
☐ Arthritis	☐ Asthma	☐ Bleeding Disorder
☐ Cancer Type: _____	☐ COPD	☐ Chicken Pox
☐ Congestive Heart Failure	☐ Diabetes Type 2	☐ Eczema
☐ Diabetes Type 1	☐ Headache	☐ Hearing Loss
☐ Fibromyalgia	☐ Herpes Simplex	☐ Herpes Zoster / Shingles
☐ Hepatitis A / B / C	☐ High Cholesterol	☐ Histoplasmosis
☐ High Blood Pressure	☐ Kidney Disease	☐ Kidney Stones
☐ HIV/ AIDS	☐ Lung Disease	☐ Lupus
☐ Liver Disease	☐ Migraine	☐ MRSA
☐ Meningitis	☐ Psychiatric Disorder	☐ Skin Cancer
☐ Polymyalgia	☐ Syphillis	☐ Thyroid Disease
☐ Stroke	☐ Wound Infection	☐ MS
☐ Toxoplasmosis	☐ Dementia	

Other _____

All Past General Surgeries / Operations: (Please list) ☐ No history of surgeries

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: **(Check family association)** ☐ None ☐ Unknown

	Maternal Parent	Paternal Parent	Grandparent	Sibling
☐ Arthritis	_____	_____	_____	_____
☐ Blindness	_____	_____	_____	_____
☐ Cancer	_____	_____	_____	_____
☐ Cataracts	_____	_____	_____	_____
☐ Diabetes	_____	_____	_____	_____
☐ Glaucoma	_____	_____	_____	_____
☐ Heart Disease	_____	_____	_____	_____
☐ High Blood Pressure	_____	_____	_____	_____
☐ Kidney Disease	_____	_____	_____	_____
☐ Lazy Eye	_____	_____	_____	_____
☐ Macular Degeneration	_____	_____	_____	_____
☐ Retinal Disease	_____	_____	_____	_____
☐ Stroke	_____	_____	_____	_____
☐ TB	_____	_____	_____	_____

Other _____

Name: _____

Social History: (Please mark all that apply)

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

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

_____

Recreational Drug Use: ☐ Yes ☐ No If yes, what and how often?

_____

Review of Systems: (Please mark all that apply) ☐ None

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

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis

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

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

Neurological
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors
- ☐ Memory Difficulty

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Musculoskeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Patient Signature: _____ Date: _____