Medical History Questionnaire

Name: ____ Nickname: _______________ Date ____/____/_____
Date of Birth ____/____/_____ Parent or Guardian: ______________________________
Address: ____ City: _________________State: _______ Zip: _________
Home Phone: ______________________Work Phone: _____________________Cell Phone: ____________________
Preferred Contact (check one): □ Home □ Cell □ Email □ Texting Ok Gender: □ Male □ Female
SSN: ___________________________Height: __________Weight: __________ Email _________________________
Employer: ___________________ Occupation: ______________ **Primary Care Physician**______________________
Who may we thank for referring you to our office? ____
Race: □ American Indian or Alaska Native (Which Tribe) ________________ □ Asian □ Black or African American
□ White □ Native Hawaiian or other Pacific Islander □ Unspecified
Ethnicity: □ Hispanic □ Not Hispanic
Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese □ Russian □ Spanish

Social History (Please mark all that apply):
Smoking: □ Current Every Day Smoker □ Current Some Days Smoker □ Former Smoker □ Never Smoked
Alcohol Use: □ Yes □ No If yes, what and how often? ___________________________________
Drug Use: □ Yes □ No If yes, what and how often? ___________________________________

Past Ocular History (Please mark all that apply):
□ Overall Healthy □ Cataracts □ Hyperopia (Far Sighted) □ Myopia (Near Sighted)
□ Amblyopia (Lazy Eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration

Other: ____

Ocular Surgeries (Please mark all that apply):
□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Blepharoplasty
□ Retinal Laser Surgery □ Glaucoma surgery □ Cataract Surgery □ LASIK
□ Eye Muscle Surgery □ Corneal Transplant

Other: ____

Ocular Significant Illnesses (Please mark all that apply):
□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens
□ AIDS □ HIV Positive □ Lupus □ Graves' Disease
□ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Rheumatoid Arthritis

Other: ____

Current Eye Medications (Please list all):

____

Systemic Illnesses (Please mark all that apply):
□ No history of illnesses □ Congestive Heart Failure □ Hepatitis □ Lung Disease
□ Anemia □ High Blood Pressure □ Lupus □ Arthritis
□ Diabetes □ High Cholesterol □ Migraine □ Arrhythmia
□ Eczema □ HIV □ Asthma □ Fibromyalgia
□ Kidney Disease □ Psychiatric Disorder □ Bleeding Disorder □ Headache
□ Skin Cancer □ Cancer □ Hearing Loss □ Liver Disease
□ Stroke □ Thyroid Disease
Other: ____

General Surgeries/Operations (Please list all):

____

____

Other Current Medications (Please list all):

____

____

Allergies to Medications/Other

____________________ Reaction: ____________ □ Mild □ Moderate □ Severe

____________________ Reaction: ____________ □ Mild □ Moderate □ Severe

____________________ Reaction: ____________ □ Mild □ Moderate □ Severe

Current or Previous Infections (Please mark all that apply):

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster/ Shingles
□ Histoplasmosis
□ HIV/AIDS
□ Meningitis
□ Wound Infection
□ Syphilis
□ Toxoplasmosis
□ MRSA

Other: ____

Family History for First Degree Relatives (parent, child, sibling)

□ Arthritis
□ Blindness
□ Cancer
□ High Blood Pressure
□ Diabetes
□ Glaucoma
□ Heart Disease
□ Retinal Disease
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Thyroid Disease
□ Stroke
□ TB
□ Cataracts
□ Lupus

Other: ____

Review of Systems (Please mark all that apply):

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters
- □ Itching
- □ Watery Eyes

Ear, Nose, and Throat
- □ Headaches / Migraines
- □ Hard of Hearing
- □ History of STD's

Genito-Urinary
- □ History of Kidney Stones
- □ History of STD's

Constitutional
- □ Weight Gain / Loss
- □ Fever

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

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

Skin
- □ Rash / Sores
- □ Hives / Eczema

Cardiovascular
- □ Heart Pain
- □ Hypertension
- □ Vascular Disease

Endocrine
- □ Thyroid Disease
- □ Diabetes

Blood/Lymphnodes
- □ Easy Bruising
- □ Prolonged Bleeding
- □ Heavy Aspirin Use
- □ Blood Clots

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

Neurological
- □ Seizures

Psychiatric
- □ Anxiety
- □ Depression

Immunologic
- □ Allergies
- □ Hives

Gastrointestinal
- □ Diarrhea
- □ Constipation

Patient Signature: ______________________________ Date: ________________

Doctor Signature: ______________________________ Date: ________________