Medical History Questionnaire

Name ____ Birth Date ______________________________

Primary Care Physician ____

Diabetes Physician____

List any medical or drug allergies and their reaction.

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List all medications currently taken (include dosage).

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SOCIAL HISTORY

Current occupation____

Tobacco Use - □ Current □ Former □ Never □ Unknown

If you use tobacco, how many packs daily and for how many years?

_______________________________ ________________________________

Alcohol Use - □ Current □ Social □ Former □ Never

If you use alcohol, how many drinks daily and for how many years?

_______________________________ ________________________________

Do you live alone? YES □ NO □

Do you drive? YES □ NO □

Do you have visual difficulty when driving? YES □ NO □

Do you have problems with night vision? YES □ NO □

Do you currently wear glasses? YES □ NO □

If YES, how long have you had the current pair? ______________________________

Do you currently wear contact lenses? YES □ NO □

Current Symptoms or Past Diagnosis and Medical History - Please mark all that apply.

GENERAL
- □ Fatigue
- □ Malaise (not feeling well)
- □ Chills
- □ Fever
- □ Night Sweats
- □ Appetite Changes
- □ Weight Changes
- □ Weakness

HEENT
- □ Head injury
- □ Decreased Hearing
- □ Tinnitus
- □ Earache
- □ Hay Fever
- □ Sinus Pain
- □ Stuffiness
- □ Discharge
- □ Dry Mouth
- □ Sore Throat

CARDIOVASCULAR
- □ Angina
- □ Heart Attack
- □ High Cholesterol
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Murmur
- □ MVP
- □ Thrombophelebitis
- □ Varicose Veins

PULMONARY
- □ COPD
- □ Wheezing
- □ Cough
- □ Hemoptysis
- □ Asthma
- □ TB
- □ SOB

DERMATOLOGICAL
- □ Rash
- □ Lumps
- □ Itching
- □ Dryness
- □ Rosacea
- □ Dermatitis
- □ Psoriasis

GASTROINTESTINAL
- □ Diarrhea
- □ Constipation
- □ Stool changes
- □ Hemorrhoids
- □ Indigestion
- □ Difficulty Swallowing
- □ Acid Reflux

GENITOURINARY
- □ Blood
- □ BPH (Benign Prostotic Hypertrophy)
- □ Difficult Urination
- □ Enlarged Prostate
- □ Increased Frequency
- □ Frequent UTI's
- □ Incontinence
- □ Kidney Stones

ENDOCRINE
- □ Polydipsia
- □ Nervousness
- □ Hypoglycemia
- □ Goiter
- □ Diabetes
- □ Hair Loss
- □ Heat/Cold Intolerance
- □ Weight Changes

PSYCHIATRIC
- □ Depression
- □ Manic- Depression
- □ Mania
- □ Anxiety
- □ Panic Attacks

HEMATOLOGICAL
- □ Easy Bruisibility
- □ Excessive Bleeding
- □ Enlarged Lymph Nodes
- □ Anemia

NEUROLOGICAL

- ☐ Alzheimer's
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headache
- ☐ Migraines
- ☐ MS
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Stroke
- ☐ TIAs
- ☐ Tremor

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Swelling
- ☐ Leg Cramps
- ☐ Stiffness
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches

PREVIOUS EYE DISEASE/PROBLEMS

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____

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FAMILY HISTORY	RELATION TO PATIENT	FAMILY HISTORY	RELATION TO PATIENT
☐ Blindness	____________________	☐ Cataract	____________________
☐ Glaucoma	____________________	☐ Macular Degeneration	____________________
☐ Retinal Detachment	____________________	☐ Thyroid Disease	____________________
☐ Arthritis	____________________	☐ Unknown	____________________
☐ Alzheimer's disease	____________________	☐ Heart Attack	____________________
☐ Diabetes	____________________	☐ Kidney Disease	____________________
☐ Heart Disease	____________________	☐ Lupus	____________________
☐ High Blood Pressure	____________________	☐ Multiple Sclerosis	____________________
☐ Parkinson's disease	____________________	☐ Sjogrens Syndrome	____________________
☐ Asthma	____________________	☐ Stroke	____________________
☐ Emphysema	____________________	☐ Tuberculosis	____________________
☐ Cancer	____________________		

LIST ANY PREVIOUS SURGERY INCLUDING EYE SURGERY	DATE
____	_____________
____	_____________
____	_____________
____	_____________

What is the main reason for today's visit? ____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING EYE SYMPTOMS?

EYES

□ Loss of vision	□ Burning
□ Distorted vision (halos)	□ Excessive tearing/watering
□ Blurred vision	□ Occasional tearing
□ Loss of side vision	□ Glare/Light sensitivity
□ Double vision	□ Eye pain or soreness
□ Decreased vision	□ Chronic infection of eye/lid
□ Mucous discharge	□ Styes, Chalazion
□ Redness	□ Fluctuating visual acuity
□ Sandy or gritty feeling	□ Tired Eyes
□ Itching	□ Floaters
□ Dryness	□ Flashes