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Medical History Questionnaire

Name: _____ Today's Date: _____

Current Age: _____ Birth Date: ____/____/____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "Yes", provide information:

EXPLANATION OF PROBLEM

Eyes	NO	YES	
Loss of Vision			
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision, halos, or glare	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashing lights or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dark spots or veils over vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossing or drifting of eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness or Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching or Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Fever, Weight loss/gain or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Males	<input type="checkbox"/>	<input type="checkbox"/>	_____
Females	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (bones/joints/muscles)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (headaches)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (diabetic/thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies, hay fever, recent cold	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other symptoms not listed above	_____		

PAST HISTORY

Please circle any allergies that you have:

Local anesthetics	Aspirin	Flourescein Dye (Iodine/Betadine)
Penicillin	Codeine or narcotics	Latex
Sulfa or other antibiotics	Shellfish	Other _____

Current Eye Medications (dosage if known)

_____	_____
_____	_____

Current medications, vitamins, or herbal supplements (dosage if known)

_____	_____
_____	_____
_____	_____

OCULAR HISTORY

Date of your last exam _____

Doctor _____

Please circle any condition that applies to you:

- | | | |
|--------------------|--------------|----------------------------------|
| Lazy eye | Cataract | Retinal detachment/tear |
| Glaucoma | Crossed eyes | Macular degeneration/pucker/hole |
| Serious eye injury | Lid problems | Diabetic retinopathy |
| Other _____ | | |

Eye surgery including laser surgery (If yes list dates, eye and surgeon) _____

MEDICAL HISTORY

Please circle any condition that applies to you:

- | | | |
|------------------|----------------------|-------------------------|
| Asthma | Emphysema | High blood pressure |
| Cancer | Stroke/TIA | Anemia |
| Thyroid disease | Arthritis/rheumatoid | HIV |
| High cholesterol | Hepatitis A/B/C | Kidney disease/dialysis |
| Migraines | Sinus infection | Low blood pressure |
| Sleep apnea | Trauma | Pregnant |

Heart disease: angina/heart attack/irregular heart beat/atrial fibrillation/stents/open heart surgery artificial valve

Other _____

If answer to Diabetes is No, skip this section

- | | |
|--------------------------|---|
| No | Yes |
| <input type="checkbox"/> | <input type="checkbox"/> Insulin required, # of years _____ |
| <input type="checkbox"/> | <input type="checkbox"/> No Insulin required |
| <input type="checkbox"/> | <input type="checkbox"/> Type I (Childhood onset) |
| <input type="checkbox"/> | <input type="checkbox"/> Type II (Adult onset) |

Age at onset: _____

Total# of years, diabetic _____

Last Hemoglobin A1C (less than 7.0%) _____

If answer to Glaucoma is No, skip this section

- Age at Diagnosis _____
 Highest intraocular pressures (if known) _____
 Previous glaucoma drops used (if known) _____

 Any allergies to glaucoma medications _____

SURGERIES:

FAMILY HISTORY

Any one in your family with any of the following: If yes, please indicate the family member.

Lazy eye _____

Glaucoma _____

Retinal detachment _____

Cancer _____

Heart disease _____

Kidney disease _____

Blindness _____

Cataract _____

Macular degeneration _____

Arthritis _____

Diabetes _____

High blood pressure _____

Stroke _____

Other _____

SOCIAL HISTORY

	<u>Yes</u>	<u>No</u>	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Drinks per day _____ per week. _____
Have you quit smoking?	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day _____ # of years _____
Do you use drugs?	<input type="checkbox"/>	<input type="checkbox"/>	How many years ago _____