

**\*\*Form must be COMPLETELY filled out for your appointment. Thank you\*\***

# **MEDICAL HISTORY QUESTIONNAIRE**

Date of Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Eye Problem: \_\_\_\_\_

Current Family Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Current Eye Doctor: \_\_\_\_\_ Location: \_\_\_\_\_

Current Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Please list all eye drops you are currently using: \_\_\_\_\_

Do you live in a Nursing Home/Assisted Living Facility:  Yes  No If Yes: Location Name: \_\_\_\_\_

Location Phone Number & Address: \_\_\_\_\_

Pneumonia Vaccination:  Yes  No

Flu Shot:  Yes  No

Are you Diabetic:  Yes  No If Yes, how old were you when you were diagnosed: \_\_\_\_\_ Stage: \_\_\_\_\_

## **YOUR EYE HISTORY**

<i>RIGHT</i>	<i>LEFT</i>		<i>RIGHT</i>	<i>LEFT</i>	
		Retinal Detachment			Amblyopia/aka "Lazy eye"
		Diabetic Retinopathy			Cataract
		Macular Degeneration			Glaucoma
		Corneal Transplant/Date:			Vein Occlusion
		Retinitis Pigmentosa			Iritis (inflammation of colored part of eye)

Eye injury:  Yes  No If Yes, Date: \_\_\_\_\_ Eye: \_\_\_\_\_ Describe: \_\_\_\_\_

Other: \_\_\_\_\_

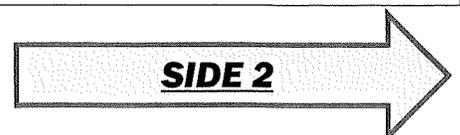
## **MEDICAL HISTORY**

Do you **CURRENTLY** have a problem with:

	Yes	No	If Yes, Explain		Yes	No	If Yes, Explain
Ears/Nose/Throat				Diabetes			
Headaches				Cancer/Lymph			
Lungs/Breathing				Cholesterol			
Heart Disease				Thyroid			
High Blood Pressure				Weight Loss/Gain			
Stomach				Bladder/Urinary			
Kidney/Stones				Bleeding Disorder			
Arthritis/Bones/Joints				Hepatitis			
Neuro/Stroke				HIV			
Psychiatric				Infectious Disease			
Are You Pregnant?				Skin Disease			

Other medical problems: \_\_\_\_\_

Please list all major illnesses:

Please list ALL previous Surgeries, General AND Eye related:

Surgery(s): please list below	Date of Surgery:	Complications:

Please list all Medications you are CURRENTLY taking and dosages:


Also, list ANY/ALL Blood thinners you are taking: \_\_\_\_\_

Please list any Drug/Food Allergies: \_\_\_\_\_ No Known Drug Allergies (NKDA)


Are you allergic to: Latex  Yes  No      Adhesives  Yes  No      Contrast Dye  Yes  No  
 Any other substance(s): \_\_\_\_\_; Reaction(s): \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Do any Family Members LIVING OR DECEASED have any of the following :

(**\*\*\*PLEASE USE THESE EXAMPLES: F -Father, M -Mother, B -Brother, S -Sister, SN -Son and/or D -Daughter\*\*\***)

DIAGNOSIS:	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Cataract			
Cancer				Amblyopia/"Lazy eye"			
Stroke				Arthritis			
Heart Disease				Headaches/Migraines			
Glaucoma				High Blood Pressure			
Macular Degeneration				Kidney Disease			
Retinal Detachment(s)				Thyroid Disease			
Blindness				Uveitis (eye inflammation)			

**SOCIAL HISTORY**

Marital Status:  Single  Married  Widowed  Divorced      Occupation: \_\_\_\_\_

Do you use drugs	Yes ( )	No ( )	If yes, please explain:
Do you currently smoke	Yes ( )	No ( )	how much per day:
Did you smoke in the past	Yes ( )	No ( )	how long did you smoke:
Do you drink alcohol	Yes ( )	No ( )	how much per day:
Do you chew tobacco	Yes ( )	No ( )	how much per day:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_, MD Date: \_\_\_\_\_