MEDICAL HISTORY QUESTIONNAIRE – OPHTHALMOLOGY

Name: ______________________________________ Nickname: __________________ Date of Birth: ____/____/______

Ethnicity: ___________ Primary Care Physician: ________________________ Referring /Specialty Dr.______________

Pharmacy:____________________________ Location__________________Pharmacy phone # (___)___-___.

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	☐ Trabeculectomy (Glaucoma surgery)
☐ Blepharoplasty	☐ Retinal Laser Surgery	☐ RK	☐ Vitrectomy
☐ Cataract Surgery	☐ LASIK	☐ Strabismus Surgery (eye muscle surgery)	☐ Other____________
☐ Corneal Transplant	☐ PRK		

Ocular Significant Illnesses: (Please mark all that apply)

☐ Overall Healthy	☐ Herpes	☐ Hypothyroidism	☐ Sjogrens
☐ AIDS	☐ HIV Positive	☐ Lupus	☐ Other____________
☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	
☐ Graves Disease	☐ Hyperthyroidism	☐ Rheumatoid Arthritis	

Infections: (Please mark all that apply)

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

Systemic Illnesses:

☐ No history of illnesses	☐ Congestive Heart Failure	☐ Hepatitis	☐ Lung Disease
☐ Anemia	☐ COPD	☐ High Blood Pressure	☐ Lupus
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Migraine
☐ Arrhythmia	☐ Eczema	☐ HIV	☐ Polymyalgia
☐ Asthma	☐ Fibromyalgia	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Bleeding Disorder	☐ Headache	☐ Kidney Stones	☐ Skin Cancer
☐ Cancer	☐ Hearing Loss	☐ Liver Disease	☐ Stroke
			☐ Thyroid Disease

Head/Ocular Trauma: (Please mark all that apply)

☐ Assault	☐ Chemical Injury	☐ Foreign Body	☐ Sharp Trauma
☐ Blunt Trauma	☐ Eye Injury	☐ Job / Sports Injury	☐ Other____________

General Surgeries / Operations: (Please list)

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Family History:

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Migraine
- ☐ Retinal Detachment
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other________

Medication Allergies:	**Reaction**	**Severity**
____________________	________________________	mild / moderate / severe
____________________	________________________	mild / moderate / severe
____________________	________________________	mild / moderate / severe
____________________	________________________	mild / moderate / severe

Current Medications / Ophthalmic Medications:

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Social History: (Please mark all that apply)

☐ Alcohol use ☐ Smoking ☐ Occupation ___________________________

Review of Systems: (Please mark all that apply)

General
- ☐ Fever
- ☐ Weight Loss /Gain
- ☐ Excess Thirst
- ☐ Loss of Appetite

Integumetary
- ☐ Acne
- ☐ Eczema
- ☐ Rosacea
- ☐ Skin Cancer

Ears
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Ear Infections
- ☐ Hearing Loss

Nose
- ☐ Broken Nose
- ☐ Post Nasal Drip
- ☐ Sinus Congestion
- ☐ Sinusitis

Mouth / Throat
- ☐ Cold Sores
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Sore Throat

Neck
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Swollen Glands
- ☐ Thyroid Mass

Respiratory
- ☐ Asthma
- ☐ Coughing up blood
- ☐ Emphysema
- ☐ Shortness of Breath

Cardiovascular
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Rate
- ☐ Pacemaker

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloody Diarrhea
- ☐ Ulcerative Colitis
- ☐ Vomitting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Frequent / Painful Urination
- ☐ Impotence

Musculoskeletal
- ☐ Ankylosing Spondylitis
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Joint Pain
- ☐ Reiter's Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Sjogren's
- ☐ Weakness

Neurological
- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Strokes
- ☐ Weakness of arms/legs

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Graves Disease
- ☐ Pituitary Tumor

Hemato-Immunologic
- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Lupus
- ☐ Lymphoma
- ☐ Swollen Lymph Nodes

Psychiatric
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Other____________

Please tell us what brings you in to see us today: ____

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Thank you for taking the time to fill out this form