**MEDICAL HISTORY QUESTIONNAIRE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |   |  | **Date of Birth:** |   |
| **Referring Doctor:** |   |  | **Primary Care Physician:** |  |   |
| **Pharmacy Name and Location (street & city):** |   |
| **Race:** | [ ]  American Indian or Alaska Native | [ ]  Asian | [ ]  Black or African American |
|  | [ ]  Native Hawaiian or Other Pacific Islander | [ ]  White |  |
| **Ethnicity:** | [ ]  Hispanic or Latino | [ ]  Not Hispanic or Latino |
| **Preferred Language:** | [ ]  English | [ ]  Spanish | [ ]  Other: |   |
| **Allergies:** | **Reaction** | **Severity** |
|   |  |   |  | [ ]  mild | [ ]  moderate | [ ]  severe |
|   |  |   |  | [ ]  mild | [ ]  moderate | [ ]  severe |
|   |  |   |  | [ ]  mild | [ ]  moderate | [ ]  severe |

|  |  |
| --- | --- |
| **Past Ocular History: (Please mark all that apply)** | [ ]  *\* Check this box if you have no history of eye problems \** |
| [ ]  Amblyopia (Lazy Eye) | [ ]  Diabetic Retinopathy | [ ]  Iritis/Uveitis |
| [ ]  Astigmatism | [ ]  Dry Eye Syndrome | [ ]  Macular Degeneration |
| [ ]  Cataracts | [ ]  Glaucoma | [ ]  Myopia (Nearsighted) |
| [ ]  Corneal Disorder | [ ]  Hyperopia (Farsighted) | [ ]  Retinal Detachment |
| [ ]  Other: |   |

|  |  |
| --- | --- |
| **Past Ocular Surgeries: (Please mark all that apply)** | [ ]  *\* Check this box if you have had no eye surgeries \** |
| **(R) (L)** | **(R) (L)** | **(R) (L)** |
| [ ]  [ ]  Blepharoplasty (Lid Surgery) | [ ]  [ ]  Glaucoma Surgery | [ ]  [ ]  Strabismus (eye muscle surgery) |
| [ ]  [ ]  Cataract Surgery | [ ]  [ ]  Laser Retinal Surgery | [ ]  [ ]  Vitrectomy |
| [ ]  [ ]  Corneal Transplant | [ ]  [ ]  LASIK/PRK/RK | [ ]  [ ]  YAG Laser Capsulotomy |
| [ ]  Other: |   |

|  |
| --- |
| **Current Eye Medications: (Please list)** |
|   |  |   |  |   |
|   |  |   |  |   |

|  |  |
| --- | --- |
| **Past Medical History: (Please mark all that apply)** | [ ]  *\* Check this box if you have no history illness \** |
| [ ]  Anemia | [ ]  Headache | [ ]  Liver Disease |
| [ ]  Arthritis | [ ]  Hearing Loss | [ ]  Lupus |
| [ ]  Arrhythmia | [ ]  Heart Attack | [ ]  Migraine |
| [ ]  Asthma | [ ]  Hepatitis | [ ]  Multiple Sclerosis |
| [ ]  Cancer | [ ]  Herpes | [ ]  Polymyalgia Rheumatica |
| [ ]  Congestive Heart Failure | [ ]  High Blood Pressure | [ ]  Psychiatric Disorder |
| [ ]  COPD | [ ]  High Cholesterol | [ ]  Rheumatoid Arthritis |
| [ ]  Diabetes ([ ]  Type 1 or [ ]  Type 2) | [ ]  HIV/AIDS | [ ]  Stroke |
| [ ]  Fibromyalgia | [ ]  Kidney Disease | [ ]  Thyroid Disease |
| [ ]  Other: |   |

|  |
| --- |
| **General Surgeries/Procedures: (Please list)** |
|   |  |   |  |   |
|   |  |   |  |   |

|  |
| --- |
| **All Other Medications: (Please list)** |
|   |  |   |  |   |
|   |  |   |  |   |
|   |  |   |  |   |

**Please continue on the next page →**

|  |  |  |
| --- | --- | --- |
| **Family History: (Please indicate relationship)** | [ ]  *\* No family history of illness \** | [ ]  *\* Family history is unknown \** |
| [ ]  Blindness |   |  [ ]  Glaucoma |   |  [ ]  Macular Degeneration |   |
| [ ]  Cancer |   |  [ ]  Heart Disease |   |  [ ]  Retinal Disease |   |
| [ ]  Cataracts |   |  [ ]  High Blood Pressure |   |  [ ]  Stroke |   |
| [ ]  Diabetes |   |  [ ]  Lazy Eye |   |  |  |
| [ ]  Other: |  |   |

|  |
| --- |
| **Social History: (Please mark all that apply)** |
| Smoking: | [ ]  current every day smoker | [ ]  current some day smoker | [ ]  former smoker | [ ]  never smoked |
| Alcohol Use: | [ ]  no | [ ]  yes | If yes, how much and how often? |   |
| Drug Use: | [ ]  no | [ ]  yes | If yes, which and how long? |   |  |   |

|  |
| --- |
| **Review of Systems: (Please mark all that apply)** |
| Eyes | Respiratory | Blood/Lymph Nodes |
|  [ ]  Previous Surgery |  [ ]  Cough |  [ ]  Easy Bruising |
|  [ ]  Contact Lens |  [ ]  Congestion |  [ ]  Gums Bleed Easy |
|  [ ]  Pain |  [ ]  Wheezing |  [ ]  Prolonged Bleeding |
|  [ ]  Double Vision |  [ ]  Asthma |  [ ]  Heavy Aspirin Use |
|  [ ]  Glaucoma |  |  |
|  [ ]  Cataracts | Gastrointestinal | Musculoskeletal |
|  [ ]  Macular Degeneration |  [ ]  Heartburn |  [ ]  Stiffness |
|  [ ]  Dry Eyes |  [ ]  Nausea / Vomiting |  [ ]  Arthritis |
|  [ ]  Flashes |  [ ]  Jaundice / Hepatitis |  [ ]  Joint Pain / Swelling |
|  [ ]  Floaters |  |  |
|  | Genitourinary | Skin |
| Ear, Nose, and Throat |  [ ]  Pain / Difficulty Urinating |  [ ]  Rash / Sores |
|  [ ]  Hard of Hearing |  [ ]  Blood in Urine |  [ ]  Lesions |
|  [ ]  Ringing in Ears |  [ ]  History of Kidney Stones |  [ ]  Hives / Eczema |
|  [ ]  Vertigo |  [ ]  History of STD's |  |
|  |  | Neurological |
| Cardiovascular | Psychiatric |  [ ]  Seizures |
|  [ ]  Chest Pain |  [ ]  Anxiety / Depression |  [ ]  Weakness / Paralysis |
|  [ ]  Dizziness |  [ ]  Mood Swings |  [ ]  Numbness |
|  [ ]  Fainting Spells |  [ ]  Difficulty Sleeping |  [ ]  Tremors |
|  [ ]  Shortness of Breath |  |  |
|  [ ]  Irregular Heart Beat | Endocrine | Immunologic |
|  [ ]  Difficulty Lying Flat |  [ ]  Increased Thirst |  [ ]  Hives |
|  |  [ ]  Increased Hunger |  [ ]  Itching |
| Constitutional |  [ ]  Increased Urination |  [ ]  Runny Nose |
|  [ ]  Fatigue / Weakness |  [ ]  Increased Sweating |  [ ]  Sinus Pressure |
|  [ ]  Fever |  [ ]  Fingernail Changes |  |
|  [ ]  Weight Gain / Loss |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Signature:** |  | **Date:** |   |