**MEDICAL HISTORY QUESTIONNAIRE**

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| **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 | |

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| **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: |  | | | |

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| **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: |  | | | |

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

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| **General Surgeries/Procedures: (Please list)** | | | | |
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| **All Other Medications: (Please list)** | | | | |
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| **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: |  |  | | | | | | | | | | | | |

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| **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? | |  | | |  |  | |

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| **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 |  |  |

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