MEDICAL HISTORY QUESTIONNAIRE

Name:____ Birth Date:____________________ Age:_________
Marital Status: ____ Single ____Married ____ Divorced ____ Widowed
Race: ____________________________________ Sex: ____Male ____ Female
Ethnicity: ____ Hispanic/Latino ____ Non-Hispanic/Non-Latino Other (specify)____________________
Language: ____English ____Spanish ____Hmong Other (specify)______________________________
Who lives in your household?____
Present Occupation:____
Name of Doctor referring you:____________________________ Clinic:______________________
Name of Primary Care Physician:________________________ Clinic:______________________
Pharmacy: ____ Location: ___________________

MEDICAL HISTORY: Please circle all major illnesses.

Anxiety	COPD	Hypertension	Lymphoma
Arthritis	Coronary Artery Disease	HIV/AIDS	Prostate Cancer
Asthma	Depression	High Cholesterol	Radiation Treatment
Atrial Fibrillation	Diabetes	Hyperthyroidism	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroidism	Stroke
Breast Cancer	Hearing Loss	Leukemia	Other ______________
Colon Cancer	Hepatitis	Lung Cancer	____________________

List all major injuries: ____
____
List all surgical procedures excluding the eye:____
____

EYE HISTORY: Please circle Y-YES or N-NO:

Y N Pain	Y N Dryness	Y N Tearing	Y N Irritation
Y N Itching	Y N Blurry Vision	Y N Redness	Y N Floaters
Y N Distortion	Y N Light Flashes	Y N Double Vision	Y N Light Sensitivity
Y N Halos around light	Y N Lazy Eye	Y N Glare	Y N Loss of Vision

Other (please describe):____

Previous eye diagnosis:____
Previous eye injuries or surgeries:____
Do you wear glasses? Y N If yes, how old are they?_______________________________________
Do you wear contacts? Y N If yes; How long?____________ **What brand?**______________**Power**: _________

FAMILY HISTORY: Please check all that apply

Please circle any blood related family members who have/had any of the following.

F – Father M – Mother B – Brother S – Sister A – Aunt U – Uncle GF – Grandfather GM - Grandmother

Diabetes	F M B S A U GF GM	Macular Degeneration	F M B S A U GF GM
Glaucoma	F M B S A U GF GM	Thyroid Disease	F M B S A U GF GM
Cataract	F M B S A U GF GM	Retinal Detachment	F M B S A U GF GM
Blindness	F M B S A U GF GM	Amblyopia/Strabismus	F M B S A U GF GM
Arthritis	F M B S A U GF GM	Heart Problems	F M B S A U GF GM
Cancer	F M B S A U GF GM	High Blood Pressure	F M B S A U GF GM
(Type) ____________________			

Other (please describe)____

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SOCIAL HISTORY

Do you smoke? YES NO If yes, how much? ________________How long?_______________Never Smoked _____

Are you a former smoker? YES When did you quit? ______________________________________

Do you drink alcohol? YES NO If yes, how often? ____

Do you drive? YES NO Please check all that apply: □ Daytime driving □ Night driving

REVIEW OF SYSTEMS

Do you currently have any symptoms/conditions in the following areas, even if controlled by medication?

If yes, please circle all that apply:

Fever Unexpected Weight Loss	Stuffy Sinuses Sore Throat Cough Trouble Swallowing	High Blood Pressure Chest Pain	Congestion Wheezing Shortness of Breath
Stomach Pain Diarrhea Urinary Frequency	Joint Pain Muscle Pain Arthritis	Rash Changing skin lesions Skin Disease/Disorder	Headache Stroke Migraine Numb/tingling hands/feet
Anxiety Depression Insomnia	Diabetes- On insulin? Y / N -How long?____________ Thyroid Abnormalities	Easy Bleeding/Bruising Anemia	Seasonal Allergies Hay Fever

Preferred Contact Method:

____ Phone ____Email ____________________________ ____Mail Other (specify) ______________________

(Email Address)

In case of emergency, whom may we contact?

Name:__________________________________ Relationship:___________________________ Phone:__________________

Name:__________________________________ Relationship:___________________________ Phone:__________________

Patient Signature:____Date: ____________________________________

Next side ➡

ALLERGIES ____ No known drug allergies

Please list any prescription or non-prescription medications that you are allergic to: ______________________________
____

Please list any allergies other than to medications: ____
____

MEDICATIONS

Please list all prescription AND non-prescription (over-the-counter) medications that you are currently taking. Include all eye drops prescription AND non-prescription (over-the-counter).

Name of Medication	Dosage	Frequency	Date Started

Patient Signature:____Date: _________________________________

Thank you!