MEDICAL HISTORY QUESTIONNAIRE

Name:_____Date:_____

In order to be compliant with insurance requirements and to eliminate extra paperwork in the long-run, we ask that you complete this form. We are required to do a review of the body's systems, and many conditions affecting these systems affect the eye. This information is kept strictly confidential; however, you may discuss portions of the questionnaire with the doctor if you prefer before completing.

Last Medical exam: ___/___/___ Primary Care Physician (PCP):_____
PCP Phone Number: _____Fax Number:_____

List any medical or eye conditions you are currently being treated for (if none, write "none"):
_____
_____
_____
_____

List any medications you are currently taking for the conditions listed above (prescription, over-the-counter, herbals; if none, write "none"):
_____
_____
_____

List any medications that you are allergic to (if none, write "none"):
_____
_____

List all major injuries, surgeries and/or hospitalizations you have had (eye and body):
_____
_____
_____
_____

Are you pregnant and/or nursing? __ No __Yes

Do you wear contact lenses? __No __ Yes; if yes, type of lens_____
If yes, brand of disinfection solution used_____

FAMILY HISTORY: these questions apply to living or deceased blood-relatives. Please indicate yes, no or ? (I'm not sure) by each of the conditions listed below:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	___	___	___	_____
Cataract	___	___	___	_____
Crossed eyes	___	___	___	_____
Glaucoma	___	___	___	_____
Macular degeneration	___	___	___	_____
Retinal detachment/ Disease	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Sarcoidosis	___	___	___	_____
Sickle Cell Trait or Disease	___	___	___	_____
Other_____	___	___	___	_____

PATIENT'S SOCIAL HISTORY: __ I would prefer to discuss my Social History directly with the Dr.

Do you drive? __No __Yes Do you have visual difficulty when driving? __No __Yes If yes, please describe:_____

Do you use tobacco products? __No__Yes If yes, type/amount/how long: _____
_____

Do you drink alcohol? __No__Yes If yes, type/amount/how long: _____
_____

Do you use illegal drugs? __No __Yes If yes, type/amount/how long: _____
_____

Have you ever been exposed to or infected with: __Gonorrhea __Hepatitis__HIV__Syphilis ____None of these

Have you ever had a blood transfusion? __No __Yes If yes, year(s)_____

REVIEW OF PATIENT'S SYSTEMS: For most of these conditions/symptoms we are looking for chronic problems. Do you currently, or have you ever had problems in the following areas? Please check no, yes or ? (not sure, undergoing testing) for each condition listed below:

SYSTEM	No	Yes	?
Constitutional			
Fever, Weight loss/gain	___	___	___
Integumentary (skin)			
Neurological			
Headaches	___	___	___
Migraines	___	___	___
Seizures	___	___	___
Eyes			
Loss of vision	___	___	___
Blurred vision	___	___	___
Distorted Vision/Halos	___	___	___
Loss of Side Vision	___	___	___
Double Vision	___	___	___
Dryness	___	___	___
Mucous Discharge	___	___	___
Redness	___	___	___
Sandy or Gritty Feeling	___	___	___
Itching	___	___	___
Burning	___	___	___
Foreign Body Sensation	___	___	___
Excess Tearing/Watering	___	___	___
Glare/Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Chronic Infection of Eye or Lid	___	___	___
Sties or Chalazion	___	___	___
Flashes/Floaters in Vision	___	___	___
Tired Eyes	___	___	___
Crossed Eyes	___	___	___
Lazy Eye	___	___	___
Drooping Eyelid	___	___	___
Prominent Eyes	___	___	___
Eye Infections	___	___	___
Glaucoma	___	___	___
Retinal Disease	___	___	___
Cataracts	___	___	___

	No	Yes	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	__	__	__
Sinus Congestion	__	__	__
Runny Nose	__	__	__
Post-Nasal Drip	__	__	__
Chronic Cough	__	__	__
Dry Throat/Mouth	__	__	__
Respiratory			
Asthma	__	__	__
Chronic Bronchitis	__	__	__
Emphysema	__	__	__
Vascular/Cardiovascular	__	__	__
Diabetes	__	__	__
Heart Pain	__	__	__
High Blood Pressure	__	__	__
Vascular Disease	__	__	__
Gastrointestinal			
Diarrhea	__	__	__
Constipation	__	__	__
Genitourinary			
Genitals/Kidney/Bladder	__	__	__
Bones/Joints/Muscles			
Rheumatoid Arthritis	__	__	__
Muscle Pain	__	__	__
Joint Pain	__	__	__
Lymphatic/Hematologic			
Anemia	__	__	__
Bleeding Problems	__	__	__
Allergic/Immunologic	__	__	__
Psychiatric	__	__	__
Endocrine			
Thyroid/Other Glands	__	__	__

If you have a condition not listed, please note here: _____
_____
_____

Dr.'s Signature_____