MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DATE: _____

Please complete the following medical history questionnaire. Place a check in front of each problem if it applies to you.

GENERAL HEALTH

OCULAR HISTORY- Have you ever had a history of:

☐ Glaucoma	☐ Double Vision	☐ Head Injury
☐ Cataracts	☐ Macular Degeneration	☐ Cataract Surgery
☐ Retinal Problems	☐ Diabetic Eye Disease	☐ Eye Muscle Surgery
☐ Headache	☐ Eye Injury	☐ Glaucoma Surgery

Other Eye Surgeries: _____

_____

EARS/NOSE/THROAT

☐ Cancer	☐ Hearing Loss	☐ Seasonal Allergies
☐ Sinus Disease		

☐ Other: _____

LUNGS

☐ COPD	☐ Lung Cancer	☐ Bronchitis
☐ Asthma	☐ Emphysema	

☐ Other: _____

HEART

☐ Hypertension	☐ Irregular Heartbeat	☐ Heart Attack
☐ High Cholesterol	☐ Congestive Heart	☐ A-Fib
☐ Pacemaker	Failure	☐ Mitral Valve Prolapse

Other: _____

STOMACH/COLON

☐ Reflux	☐ Cancer	☐ GERD
☐ Ulcers	☐ Irritable Bowel	☐ Chron's Disease
☐ Diverticulitis	Syndrome	

Other: _____

KIDNEY/PROSTATE/BLADDER/GENITALS

☐ Kidney Disease	☐ Kidney Stones	☐ Cancer
☐ Prostate Enlargement		

☐ Other: _____

ENDOCRINE

☐ Diabetes, Non-Insulin	☐ Thyroid	☐ Lupus
☐ Diabetes, Insulin		

Average Blood Sugar: _____ Hemoglobin A1C: _____

MEDICAL HISTORY QUESTIONNAIRE

NEUROLOGIC

- ☐ Stroke, When: _____
- ☐ Head Injury
- ☐ Seizures
- ☐ Dementia
- ☐ Downs Syndrome
- ☐ Alzheimer's
- ☐ Migraine Headaches
- ☐ Parkinson's
- ☐ Tremors
- ☐ Other: _____

PSYCHIATRIC

- ☐ Depression
- ☐ Psychosis
- ☐ Anxiety
- ☐ ADD
- ☐ ADHD
- ☐ Other: _____

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Fibro Myalgia
- ☐ Joint Pain/Joint Swelling
- ☐ Other: _____

SKIN/BREAST

- ☐ Skin Cancer
- ☐ Rash
- ☐ Rosacea
- ☐ Breast Cancer
- ☐ Eczema
- ☐ Other: _____

BLOOD/LYMPHATICS

- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Other: _____

IMMUNE SYSTEM/INFECTIONS

- ☐ HIV
- ☐ AIDS
- ☐ Polio
- ☐ Shingles
- ☐ Chicken Pox
- ☐ Tuberculosis
- ☐ Lyme Disease
- ☐ Herpes Simplex Virus
- ☐ Hepatitis
- ☐ Histoplasmosis
- ☐ Other: _____

RHEUMATOLOGIC

- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Other: _____

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Hip
- ☐ Breast Biopsy
- ☐ C-Section
- ☐ Thyroidectomy
- ☐ Coronary Artery Bypass
- ☐ Mitral Valve Repair/Replacement
- ☐ Adenoidectomy
- ☐ Gall Bladder
- ☐ Knee
- ☐ Lumpectomy
- ☐ Gastric
- ☐ Angioplasty
- ☐ Hernia Repair
- ☐ Back
- ☐ Mastectomy
- ☐ Prostate Surgery
- ☐ Heart Transplant
- ☐ Heart Stent
- ☐ Aortic Valve Repair/Replacement
- ☐ Tonsillectomy
- ☐ Rotator Cuff
- ☐ Hysterectomy
- ☐ Plastic Surgery
- ☐ Pacemaker/ICD
- ☐ Other: _____

MEDICAL HISTORY QUESTIONNAIRE

DRUG ALLERGIES: _____

_____

OTHER ALLERGIES: _____

LATEX ALLERGY: ○ yes ◉ no

CURRENT MEDICATIONS (Please include vitamins, supplements and eye drops):

_____

_____

_____

_____

_____

PHARMACY NAME & LOCATION: _____

FAMILY HISTORY -Has anyone in your family ever been diagnosed with the following:

☐ Diabetes ☐ Macular Degeneration ☐ Cancer
☐ Glaucoma ☐ Blindness
☐ Cataracts ☐ Crossed Eyes
☐ Other: _____

SOCIAL HISTORY

Alcohol Use: ☐ Never ☐ Occasionally ☐ Socially ☐ Moderately Every Day
☐ Heavy ☐ Quit

Tobacco Use: ☐ Current Every Day Smoker ☐ Current Some Day Smoker
☐ Former Smoker ☐ Never Smoker ☐ Unknown

PRIMARY MEDICAL PHYSICIAN: _____

PRIMARY EYE PROVIDER: _____
(Optometrist/Ophthalmologist)

REFERRED BY DOCTOR: _____

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino

PREFERRED LANGUAGE

☐ English ☐ Spanish; Castilian

RACE

☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White ☐ Other: _____

Reviewed By: _____