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Medical History Questionnaire

Name: ____________________ **Date Of Birth:** ____________________

Pharmacy: ____________________ **Location:** ____________________

Reason for Today's Visit: ____________________

____

Current Symptoms (*Check all that apply*)

☐ Flashes	☐ Floaters	☐ Distortion	☐ Blurred Vision
☐ Visual Field Defect	☐ Blank Spots	☐ Watery Eyes	☐ Pain/Irritation
☐ Light Sensitivity	☐ Discharge	☐ Double Vision	☐ Foreign Body Sensation

☐ Other: ____________________

Past Ocular History (*Check All That Apply*)

☐ Overall Healthy	☐ Astigmatism	☐ Cataracts	☐ Diabetic Retinopathy
☐ Dry Eyes	☐ Glasses/Contacts	☐ Glaucoma	☐ Optic Neuritis
☐ Ret. Detachment	☐ Retinal Tear	☐ Eye Trauma	☐ Prosthetic

☐ Other: ____________________

Ocular Surgeries (*Check All That Apply*)

☐ No Ocular Surgery	☐ Facial Cosmetic	☐ Cataract	☐ Corneal Transplant
☐ Foreign Body Removal	☐ Retinal Laser	☐ LASIK	☐ LASEK
☐ Radial Keratotomy	☐ Punctal Plugs	☐ Strabismus Surgery	☐ Glaucoma Surgery
☐ Vitrectomy	☐ Scleral Buckle	☐ Enucleation	☐ Other: __________

Family History (*Check All That Apply*)

☐ Blindness	☐ Cancer	☐ Cataracts	☐ Diabetes
☐ Glaucoma	☐ Retinal Detachment	☐ Mac. Degeneration	☐ Kidney Disease
☐ High Blood Pressure	☐ Migraine	☐ Heart Disease	☐ Stroke
☐ Thyroid Disease	☐ Other: __________		

Review of Systems (*Check All That Apply*)

Integumentary (Skin)

- [ ] Skin Cancer
- [ ] Eczema
- [ ] Psoriasis
- [ ] Rosacea
- [ ] Other: ______________________

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Emphysema
- [ ] COPD
- [ ] Lung Cancer
- [ ] Tuberculosis (TB)
- [ ] Other: ______________________

Cardiovascular

- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Atherosclerosis
- [ ] Heart Disease
- [ ] Arrhythmia
- [ ] Pacemaker
- [ ] Heart Attack
- [ ] Other: __________

Gastrointestinal

- [ ] Colon Cancer
- [ ] Liver Cancer
- [ ] Constipation
- [ ] Ulcers
- [ ] Reflux/Heartburn
- [ ] Other: ______________________

Genitourinary

- [ ] Kidney Disease
- [ ] Prostate Cancer
- [ ] Ovarian/Uterine CA
- [ ] Other: __________

Musculoskeletal

- [ ] Rheum. Arthritis
- [ ] Arthritis
- [ ] Fibro/Polymyalgia
- [ ] Sarcoidosis
- [ ] Osteoporosis
- [ ] Gout
- [ ] Other: ______________________

Neurological

- [ ] Bell's Palsy
- [ ] Dementia
- [ ] Brain Tumor
- [ ] Parkinson's Disease
- [ ] Migraines/Headaches
- [ ] Multiple Sclerosis
- [ ] Meningitis
- [ ] Seizures
- [ ] Stroke (CVA)
- [ ] Dizziness
- [ ] Hearing Loss
- [ ] Other: __________

Endocrine

- [ ] Type I Diabetes
- [ ] Type II Diabetes
- [ ] Diabetic Suspect
- [ ] Hypothyroidism
- [ ] Hyperthyroidism
- [ ] Graves' Disease
- [ ] Pituitary Tumor
- [ ] Other: __________

Hematologic/Lymphatic

- [ ] AIDS/HIV
- [ ] Anemia
- [ ] Bleeding Disorder
- [ ] Breast Cancer
- [ ] Hepatitis A/B/C
- [ ] Leukemia
- [ ] Lupus
- [ ] Lyme Disease
- [ ] Lymphatic Cancer
- [ ] Herpes Simplex
- [ ] Herpes Zoster
- [ ] Histoplasmosis
- [ ] Shingles
- [ ] Syphilis
- [ ] Toxoplasmosis
- [ ] Other: __________

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Bipolar Disorder
- [ ] PTSD
- [ ] Schizophrenia
- [ ] Other: ______________________

Other Medical Diseases (Please List)

____
____
____

General Surgeries / Operations (*Please List*)

______________	______________
______________	______________
______________	______________

Medication Allergies	Reaction	Severity
______________	______________	☐ Mild ☐ Moderate ☐ Severe
______________	______________	☐ Mild ☐ Moderate ☐ Severe
______________	______________	☐ Mild ☐ Moderate ☐ Severe
______________	______________	☐ Mild ☐ Moderate ☐ Severe

Any Sensitivity To

☐ Betadine ☐ Iodine ☐ Adhesive Tape ☐ Erythomycin

Current Medication / Eye Drops / Vitamins / Minerals

________	________	________	________
________	________	________	________
________	________	________	________

Social History

Alcohol Use:	☐ Yes ☐ No ☐ Former How Often: _____ times per ☐ Year ☐ Month ☐ Week ☐ Day
Tobacco Use:	☐ Yes ☐ No ☐ Former How Often: _____ times per ☐ Year ☐ Month ☐ Week ☐ Day
Drug Use:	☐ Current ☐ Past ☐ Never
Occupation:	______________________________ ☐ Full Time ☐ Part Time ☐ Retired
Student:	☐ Yes ☐ No
Pregnant or Nursing:	☐ Yes ☐ No Delivery Date: ______________
Living Situation:	☐ Alone ☐ With Family ☐ Care Facility

Signature ______________________________ **Date:** ______________