Medical History Questionnaire

Name:_____ Nickname:_____ Date of Birth:____/____/____

Address:_____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ Email:_____

Parent/Guardian Name (If patient is a child):_____

Preferred Contact □Home □Cell □Email Social Security Number: _____

Gender: □ Male □ Female Height: _____ Weight: _____

Primary Care Physician: _____Pharmacy:_____

Race: □American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander

□White □Unspecified

Ethnicity: □Hispanic □Not Hispanic

What is your primary reason for visit today?_____

Systemic Illnesses:

□ No History of Illness	□Colitis	□ Hearing Loss	□Liver Disease	□Prostate Disease
□Anemia	□ Congestive Heart Failure	□Heart Disease	□Lung Disease	□Psychiatric Disorder
□Ankylosing Spondylitis	□ COPD	□Hepatitis	□Lupus	□Rheumatoid Arthritis
□Arthritis	□Crohn's Disease	□Herpes Simplex/Zoster	□Meningitis	□Sjogren's Syndrome
□Arrhythmia	□Diabetes: Type 1 or 2	□High Blood Pressure	□Migraine	□Stroke
□Asthma	A1C:___, CBG:___	□High Cholesterol	□MRSA	□Syphilis
□Bleeding Disorder	□Eczema	□Histoplasmosis	□Multiple Sclerosis	□Thyroid Disease
□Cancer	□Emphysema	□HIV/AIDS	□Osteoporosis	□Toxoplamsosis
□Celiac Disease	□Fibromyalgia	□Kidney Disease	□Polymyalgia	
□Chicken Pox	□Headache	□Kidney Stones	□Pregnant/Nursing	

Other (Please Specify):_____

Medications: **Name** **Dosage** **Frequency**

1._____

2._____

3._____

4._____

5._____

Please put additional medications at the bottom of Page 2

Allergies (Medications, Materials, Environmental):

_____

_____

Past Ocular History (Please mark all that apply)

□Cataract □Macular Degeneration □Glaucoma □Diabetic Retinopathy □Dry Eye
□Eye Infection □Floaters/Flashes of light □Iritis or Uveitis □Retinal defects or degenerations

Other (Please Specify):_____

Ocular Surgeries:_____

Social History (Please mark all that apply)

Smoking: □Current Every Day Smoker □Current Some Days Smoker □Former Smoker □Never Smoked

Alcohol Use: □Yes □No If yes, what and how often?_____

Drug Use: □Yes □No If yes, what and how often?_____

Family Medical History (Parents, Siblings, and Children): Please indicate who is affected

□Cancer_____ □Diabetes Type 1 or 2_____ □Hypertension_____

□Thyroid Condition: Hypo or Hyper_____ □Cataract_____

□Macular Degeneration_____ □Glaucoma_____

Other (Please Specify):_____

Review of Systems (Please mark all that apply currently)

Constitution
- □Developmental Disabilities
- □Cancer
- □Fatigue
- □Weight loss/gain

Eyes
- □Contact Lens Wearer
- □Eye Pain
- □Double Vision

Ears, Nose, Throat
- □Hearing Loss
- □Sinusitis
- □Dry Mouth

Neurological
- □Seizures
- □Muscle Weakness
- □Numbness
- □Cerebral Palsy
- □Migraine
- □Autism Spectrum Disorder

Psychiatric
- □Depression
- □Anxiety
- □Attention Deficit
- □Bipolar Disorder
- □Mood Swings
- □Difficulty Sleeping

Cardiovascular
- □Chest Pain
- □Dizziness
- □Fainting Spells
- □Shortness of Breath

Respiratory
- □Difficulty Breathing
- □Coughing
- □Wheezing

Gastrointestinal
- □Ulcer
- □Acid Reflux

Genito-Urinary
- □Difficulty Urinating
- □Blood in Urine

Musculoskeletal
- □Stiffness
- □Joint pain/Swelling

Integumentary
- □Rashes
- □Eczema
- □Rosacea

Endocrine
- □Increase Thirst
- □Increased Hunger
- □Increased Urination

Heme/Lymph
- □Bruise/Bleed Easily

Allergy/Immunologic
- □Hives
- □Itching

Other (Please Specify):_____

Additional Medications:

_____

_____

_____