**MEDICAL HISTORY QUESTIONNAIRE**

 **NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYSTEMS**

 **Primary reason for today’s (first) visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Do you presently have any or currently experiencing any problems in the following areas?**

 **If “YES”, give an explanation**.

 **YES**  **NO EXPLANATION OF PROBLEM**

 **Constitutional**

 **Chronic fever, unexplained weight loss [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Eyes WHICH EYE?**

 **Blurred vision [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Distortion of vision [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **(example: straight lines look wavy)**

 **Loss of central or side vision [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Floaters / Cobwebs [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Flashes of Light [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Eye pain [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Light Sensitivity [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Double Vision [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Decreased Vision [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Itching, burning [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Discharge, redness [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Gritty felling, dryness [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Tearing [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Feels like something in eye [ ] [ ] Right\_\_\_\_\_\_ Left\_\_\_\_\_\_ Both\_\_\_\_\_\_**

 **Ears, Nose, Mouth, Throat EXPLANATION OF PROBLEM**

 **Hearing loss, sinus problems [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cardiovascular**

 **Chest pain, irregular heart beat [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Respiratory**

 **Shortness of breath, wheezing [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Gastrointestinal**

 **Abdominal pain, nausea [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYSTEMS (cont’d)**

 **YES**  **NO EXPLANATION OF PROBLEM**

 **Genitourinary**

 **Blood in urine, discomfort on urination [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Musculoskeletal**

 **Joint pain [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Integumentary**

 **Skin rashes, itching, pigmented lesion [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Neurological**

 **Numbness, muscular weakness, headache [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Psychiatric**

 **Feeling of sadness, anxiety [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Endocrine**

 **Excessive thirst, excessive urination [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cold intolerance [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Hematologic/lymphatic**

 **Easy bleeding, easy bruising [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Swollen glands [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Allergic/immunologic**

 **Seasonal allergies, hives [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Do you have any medication allergies? [ ] NO [ ] YES (please list)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **List any medications (other than eyedrops) that you are currently using:**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**3. Were you born premature? [ ] NO [ ] YES**

**PAST EYE HISTORY**

 **YES**  **NO WHICH EYE?**

  **1. Have you ever had an eye injury: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

  **2. Have you ever cataract surgery: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **3. Do you have Glaucoma: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **4. Are you on eye drops for Glaucoma: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **5. Have you had surgery of Glaucoma: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **6. Do you have a history of Retinal disease: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **7. Do you have a history of Macular Degeneration: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **8. Do you have a history of Diabetic Retinopathy: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **9. Have you been treated for Retinal Disease: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **If yes, please answer the following questions:**

 **Injection of medication: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **Laser treatment: [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **Surgery treatment (hospital setting): [ ] [ ] Right\_\_\_\_Left\_\_\_\_ Both\_\_\_\_\_\_\_**

 **Name of surgery (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **10. Eye drops currently in use: (list) [ ] [ ]**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PAST MEDICAL / SURGICAL HISTORY**

1. **Are you being treated for any medical conditions?**

 **YES NO YES NO**

  **Diabetes: [ ] [ ] Heart Disease (irregular heart [ ] [ ]**

 **Do you use Insulin: [ ] [ ] beat, heart attack, bypass surgery)**

 **Stroke: [ ] [ ] Renal Disease : [ ] [ ]**

 **High Blood Pressure: [ ] [ ] Are you on Dialysis: [ ] [ ]**

 **Rheumatoid Arthritis: [ ] [ ]**

1. **List any major surgical procedures (except eye):**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **FAMILY HISTORY**

 **YES NO EXPLANATION / RELATIONSHIP OCULAR**

  **Blindness [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Night Blindness [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cataract [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Glaucoma [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Macular degeneration [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Retinal detachment [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Other (list) [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MEDICAL**

 **Diabetes [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **High Blood Pressure [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Heart Disease [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Rheumatoid Arthritis [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Other (list) [ ] [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SOCIAL HISTORY**

 **GENERAL**

 **Do you drink alcohol? [ ] [ ] How much per day?\_\_\_\_\_\_\_\_\_\_\_Years?\_\_\_\_\_\_\_\_**

 **Do you smoke? [ ] [ ] How many packs per day?\_\_\_\_\_\_\_Years?\_\_\_\_\_\_\_**

 **Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**