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

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

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