MEDICAL HISTORY QUESTIONNAIRE

NAME: ____ D.O.B. ____________________ DATE: ___________________

Date of last eye exam: _____________________________ Referred by: ____

PREFERRED METHOD OF CONTACT: [ ] Home phone [ ] Cellphone [ ] E-mail [ ] Mail [ ] Text [ ] Other: ______________

PRIMARY PHYSICIAN: ____ PHONE: ___________________________

PHARMACY: ____ PHONE: _______________ FAX: __________________

RACE: Please pick one [ ] American Indian or Alaskan Native Alone [ ] Asian [ ] Black or African American [ ] White
[ ] Native Hawaiian or other Pacific Islander [ ] Other [ ] Unknown or Decline to provide

ETHNICITY: Please pick one [ ] Hispanic or Latino [ ] Non-Hispanic or Non-Latino [ ] Unknown or Decline to provide

PREFERRED LANGUAGE:

Do you have any **ALLERGIES** to any medications (including eye drops, food, animals, hay fever, etc.)? [ ] YES [ ] NO

IF YES, list all the medications, substances, and type of allergic reactions:

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Please list all **MEDICATIONS** that you currently take and for what reason you are taking them, including **EYE MEDICATIONS** and over the counter meds (list the strength and how often you take it):

Medications and reason	Strength (dose)	Frequency (how often)

EYE HISTORY : Have you ever been told you have any of the following eye conditions?

	YES	NO	Explanation (year diagnosed, dates of surgery/laser)
Do you currently wear glasses?			If yes, how long have you had current pair? ___yrs
Amblyopia (a lazy eye)			
Cataracts			
Glaucoma (high eye pressure, optic nerve damage, visual field defects)			
Macular degeneration			
Retinal tear or detachment			If yes, how was it treated ? [ ] Freezing/laser [ ] Surgery When? ________________________
Strabismus (crossed eyes)			
Other			

MEDICAL HISTORY AND REVIEW OF SYSTEMS: Have you ever been **DIAGNOSED** with any of the following illnesses or do you **CURRENTLY** have any **SYMPTOMS/PROBLEMS** in any of the following areas? Please check the box if listed, or write in the diagnoses under "other".

SYSTEM	SYMPTOMS/PROBLEMS	YES	NO
GENERAUCONSTITUTIONAL	Fever		
HEAD,EYES, EARS, NOSE, THROAT	Sinus problems		
	Hearing loss		
RESPIRATORY	Asthma		
CARDIOVASCULAR	Arrhythmia		
GASTROINTESTINAL	Vomiting		
METABOLIC/ ENDOCRINE	Heat intolerance		
NEUROLOGICAL	Balance disturbances		
INTEGUMENTARY	Dry skin		
	Rash		
MUSCULOSKELETAL	Joint swelling		
HEMATOLOGIC/ LYMPHATIC	Bleeding		
OTHER (Anything for which you see a health care provider on a regular basis)			

Please also **list any surgeries** you have had and approximate date of the procedure.

FAMILY HISTORY M = mother F = father B = brother S = sister GP = grandparent C = child

DISEASE	YES	NO	RELATIONSHIP	DISEASE	YES	NO	RELATIONSHIP
Blindness			M F B S GP C	Cataracts			M F B S GP C
Glaucoma			M F B S GP C	Macular Degeneration			M F B S GP C
Cancer			M F B S GP C	Diabetes			M F B S GP C
Heart disease			M F B S GP C	Kidney disease			M F B S GP C
Hypertension			M F B S GP C	Arthritis			M F B S GP C
Lupus			M F B S GP C	Stroke			M F B S GP C
Thyroid disease			M F B S GP C	Other			M F B S GP C

SOCIAL HISTORY

Have you ever smoked? [ ] YES [ ] NO Age started: ____ Age stopped: ____

Tobacco Type: [ ] Cigarette [ ] Cigar [ ] Pipe [ ] Chewing [ ] Smokeless [ ] Snuff

ADVANCE DIRECTIVES (check all that apply)

I have: [ ] Living Will [ ] Power of Attorney (POA) Type of POA ______________________________________

I am interested in receiving information regarding Advance Directives [ ] Yes [ ] No

Patient's Signature: ____________________________________ Date: ______________________

Physician's Signature: ___________________________________ Date: ______________________