MEDICAL HISTORY QUESTIONAIRE

_____ _____

Name Social Security Number

Preferred Language? __English __Spanish __Other please list_____

Race? __White/Caucasian __Black/African __Asian __Amer. Indian __Pacific Islander __ Unknown

Ethnicity? __Non-Hispanic __Hispanic

Do you have allergies to any medications?_____
List all known eye diseases:_____

List all eye surgeries you have had:_____

List your eye medications:_____

List your medical conditions:_____

List other surgeries you have had:_____

List your other medications:_____

Do you have any family history of: _ Diabetes, _ Cancer, _ Heart disease, _ Stroke, _TB, _ Kidney Disease, _Blindness, _ Cataracts, _ Glaucoma, _Macular Degeneration, _ Retinal Disease, _ High Blood Pressure, _ Arthritis, _ Lazy Eye, _ Other eye disease_____
Do you smoke? **Yes** **No** If yes, what and how much?_____
If you quit smoking, when did you do so? _____
Do you drink alchohol? **Yes** **No** If yes, how often and how much?_____
Do you abuse drugs? **Yes** **No** If yes, please provide detail:_____

Review of Systems: Please check all that apply to you.

Eyes
__Previous surgery
__Contact Lenses
__Pain
__Double Vision
__Glaucoma
__Cataracts
__Macular Degeneration
__Dry Eyes
__Flashes
__Floaters

Ear, Nose, and Throat
__Hard of Hearing
__Ringing in Ears
__Vertigo

Cardiovascular
__Chest pain
__Dizziness
__Fainting Spells
__Shortness of Breath
__Irregular Heart Beat
__Difficulty Lying Flat

Respiratory
__Cough
__Congestion
__Wheezing
__Asthma

Gastrointestinal
__Heartburn
__Nausea/Vomiting
__Jaundice
__Hepatitis

Genitourinary
__Pain/Difficulty
__Blood in Urine
__History of Kidney Stones
__History of STD's

Psychiatric
__Anxiety/Depression
__Mood Swings
__Difficulty Sleeping

Blood/ Lymph Nodes
__East Bruising
__Gums Bleed Easily
__Prolonged Bleeding
__Heavy Aspirin Use

Musculoskeletal
__Stiffness
__Arthritis
__Joint Pain/Swelling

Skin
__Rashes/Sores
__Lesions
__Hives/Eczema

Neurological
__Seizures
__Weakness/Paralysis
__Numbness
__Tremors