

Patient Name: _____ Date: _____

Patient Occupation: _____ Primary Care Physician: _____

How did you hear about us? Insurance Co. Yellow Pages Family/Friend Drove by

MEDICAL HISTORY QUESTIONNAIRE

Please indicate if you have or have ever had any problems in the following areas:

	YES	NO		YES	NO
EYES			ENDOCRINE		
Blurred Distance Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Eye Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dry/Sandy Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Droopy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY (Skin)		
Squinting	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Rubbing	<input type="checkbox"/>	<input type="checkbox"/>	Acne Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC		
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Easily	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC/IMMUNOLOGIC			MUSCULOSKELETAL		
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
CANCER type _____	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR			Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			PSYCHIATRIC		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU PREGNANT OR NURSING?	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>

Please list any previous eye surgeries you have had: _____

SOCIAL HISTORY: This information is kept strictly confidential

Do you smoke? yes no

Do you drink alcohol? yes no

Do you use illegal drugs? yes no

FAMILY HISTORY

DISEASE/CONDITION	YES	NO	PLEASE CIRCLE RELATIONSHIP TO YOU				
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	mom – dad – maternal	grandma – maternal	grandpa – paternal	grandma – paternal	grandpa – brother – sister