MEDICAL HISTORY QUESTIONNAIRE DATE_____

NAME_____DOB_____

PHARMACY_____

LOCATION (STREET &CITY)_____

PAST OCULAR HISTORY: □ OVERALL HEALTHY □ CATARACTS □ AMBLYOPIA

□DIABETIC RETINOPATHY □IRITIS □OPTIC NEURITIS □APHAKIA □ DRY EYES
□ KERATOCONUS □ASTIGMATISM □ GLAUCOMA □MACULAR DEGENERATION
□ ARTERY/VEIN OCCLUSION □ HYPEROPIA (FAR SIGHTED) □ MYOPIA (NEAR SIGHTED)
OTHER_____

PAST OCULAR SURGERIES: □ NONE □ BLEPHAROPLASTY □ CATARACT SURGERY

□ CORNEAL TRANSPLANT □ RETINAL LASER SURGERY □ STRABISMUS SURGERY

□ TRABECULECTOMY □VITRECTOMY □ LASIK □ PRK □ RK
OTHER_____

PAST MEDICAL HISTORY:

□NO HISTORY OF ILLNESS
□AIDS
□CONGESTIVE
□HIV
□MIGRAINE
□ANEMIA
□COPD
□KIDNEY DISEASE
□PARKINSONS
□ARRHYTHMIA
□DIABETES I / II
□LIVER DISEASE
□POLYMYALGIA
□ARTHRITIS
□FIBROMYALGIA
□LUNG DISEASE
□PSYCHIATRIC DISORDER
□ASTHMA
□HEPATITIS
□LUPUS
□SJOGRENS
□BLEEDING DISORDER
□HIGH BLOOD PRESSURE
□MENINGITIS
□SKIN CANCER
□CANCER
□HIGH CHOLESTEROL
□MERSA
□STROKE
□HEART FAILURE
□TEMPORAL ARTERITIS
□TUBERCULOSIS

OTHER_____
_____

PAST SURGERIES: □ NONE

_____
_____

FAMILY HISTORY □ NONE
□DIABETES □STROKE □BLINDNESS □MACULAR DEGENERATION □ARTHRITIS
□CANCER □TB □CATARACTS □RETINAL DISEASE □LAZY EYE
□HEART DISEASE □KIDNEY DISEASE □GLAUCOMA □HIGH BLOOD PRESSURE
□OTHER/EXPLANATION_____

SMOKING STATUS: □NEVER SMOKED
□CURRENT EVERY DAY □CURRENT SOME DAY SMOKER □FORMER SMOKER

ALCOHOL USE _YES _NO IF YES, HOW MUCH AND HOW OFTEN_____

DRUG USE _YES _NO IF YES, WHAT AND HOW OFTEN_____

REVIEW OF SYSTEMS:

EYES
□PREVIOUS SURGERY
□CONTACT LENS
□PAIN
□DOUBLE VISION
□ MACULAR DEGENERATION
□CATARACT
□GLAUCOMA
□DRY EYES
□FLASHES
□FLOATERS

RESPIRATORY
□COUGH
□CONGESTION
□WHEEZING
□ASTHMA

BLOOD/LYMPH NODES
□EASY BRUISING
□GUMS BLEED EASILY
□PROLONGED BLEEDING
□HEAVY ASPIRIN USE

GASTROINTESTINAL
□HEARTBURN
□NAUSEA/VOMITING
□JAUNDICE/HEPATITIS

MUSCULOSKELATAL
□STIFFNESS
□ARTHRITIS
□JOINT PAIN/SWELLING

EAR, NOSE, THROAT
□HARD OF HEARING
□RINGING IN THE EARS
□VERTIGO

GENITO-URINARY
□PAIN/DIFFICULTY
□BLOOD IN URINE
□HISTORY OF KIDNEY STONES
□HISTORY OF STD'S

SKIN
□RASH/SORES
□LESIONS
□HIVES/ECZEMA

CARDIOVASCULAR
□CHEST PAIN
□DIZZINESS
□FAINTING SPELLS
□SHORTNESS OF BREATH
□IRREGULAR HEARTBEAT
□DIFFICULTY LYING FLAT

PSYCHIATRIC
□ANXIETY/DEPRESSION
□MOOD SWINGS
□DIFFICULTY SLEEPING

NEUROLOGICAL
□SEIZURES
□WEAKNESS/PARYALYSIS
□NUMBNESS
□TREMORS

ENDOCRINE
□INCREASED THIRST
□INCREASED HUNGER
□INCREASED URINATION
□INCREASED SWEATING
□FINGERNAIL CHANGES

IMMUNOLOGIC
□HIVES
□RUNNY NOSE
□ITCHING
□SINUS PRESSURE

CONSTITUTIONAL
□FATIGUE/WEAKNESS
□FEVER
□WEIGHT LOSS/GAIN