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____

*****PLEASE TURN THIS PAGE OVER AND COMPLETE THE OTHER SIDE*****

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	RESPIRATORY	BLOOD/LYMPH NODES
☐PREVIOUS SURGERY	☐COUGH	☐EASY BRUISING
☐CONTACT LENS	☐CONGESTION	☐GUMS BLEED EASILY
☐PAIN	☐WHEEZING	☐PROLONGED BLEEDING
☐DOUBLE VISION	☐ASTHMA	☐HEAVY ASPIRIN USE
☐GLAUCOMA	☐NAUSEA/VOMITING	☐GASTROINTESTINAL
☐MACULAR DEGENERATION	☐JAUNDICE/HEPATITIS	☐HEARTBURN
☐DRY EYES	☐STIFFNESS	☐ARTHRITIS
☐FLASHES		☐JOINT PAIN/SWELLING

□FLOATERS

□CATARACT

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

IMMUNOLOGIC

□HIVES

□ITCHING

□RUNNY NOSE

□SINUS PRESSURE

CONSTITUTIONAL

□INCREASED URINATION

□FEVER

□WEIGHT LOSS/GAIN

□FATIGUE/WEAKNESS

□FINGERNAIL CHANGES

□MUSCULOSKELETAL

□INCREASED SWEATING