MEDICAL HISTORY QUESTIONNAIRE- OPHTHALMOLOGY

Name: _____ **Date of Birth**_____

Primary Care Physician: _____

***Ethnicity**: (Please circle one) Hispanic or Latino / Not Hispanic or Latino

***Race**: (Please circle one) American Indian or Alaska Native / Asian / African American or Black / Native Hawaiian or other pacific Islander / White or Caucasian / Other

***Any Disabilities**:_____

***Flu Vaccine this season?** Applicable (Oct 1st- March 31st) **Yes/ No**

***Over age 65:** Have you ever received a pneumonia vaccine? **Yes/ No**

*Government mandated questions

Vision is currently corrected with: Glasses Contact Lenses Neither

Past Ocular History: (Please mark all that apply):

- ☐ Overall healthy
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Amblyopia (Lazy eye)
- ☐ Dry Eyes
- ☐ Keratoconus
- ☐ Iritis
- ☐ Optic Neuritis
- ☐ Ocular Trauma: _____
- ☐ Other: _____

Ocular Surgeries: (Please mark all that apply):

- ☐ No ocular surgeries
- ☐ Cataract surgery
- ☐ LASIK
- ☐ PRK
- ☐ Blepharoplasty
- ☐ Strabismus surgery (eye muscle surgery)
- ☐ Retinal laser surgery
- ☐ Trabeculectomy (Glaucoma surgery)
- ☐ SLT (Glaucoma laser)
- ☐ Corneal Transplant
- ☐ Other: _____

Infections: (Please mark all that apply):

- ☐ Overall healthy
- ☐ Chicken Pox
- ☐ Herpes Simplex
- ☐ Herpes Zoster/Shingles
- ☐ Hepatitis A / B / C
- ☐ Toxoplasmosis
- ☐ MRSA
- ☐ HIV/ AIDS
- ☐ Other:_____

Systemic Illnesses: (Please mark all that apply):

- ☐ No History of illnesses
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer: Please specify _____
- ☐ COPD
- ☐ Diabetes
- ☐ Fibromyalgia

☐ Graves Disease
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Lupus
☐ Multiple Sclerosis
☐ Migraine
☐ Psychiatric Disorder_____
☐ Rheumatoid Arthritis
☐ Stroke
☐ Sjogrens
☐ Thyroid Disease
☐ Other_____

Please continue on to other side

General Surgeries/ Operations: (Please List)

_____
_____
_____

Family History: (Please specify: Mother (**M**), Father (**F**), Sibling (**S**), Child (**C**)

_____Blindness
_____Cataracts
_____Glaucoma
_____Macular Degeneration
_____Lazy Eye
_____Retinal Detachment
_____Diabetes
_____High Blood Pressure
_____Migraine
Other significant family illness_____

☐ **No Significant Family History**
☐ **Adopted**

Current Medications: (Please list all medications you take with strengths if known, including eye drops)

_____
_____
_____
_____
_____
_____

Medication Allergies:	**Reaction**	**Severity**
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe
_____	_____	Mild / Moderate / Severe

Pharmacy: _____ **Location:** _____

Social History: (Please mark all that apply)

Alcohol Use- (Please circle one) None Occasional Social Daily

Smoking- (Please circle one) Never Occasional Daily Former: Quit _____

Occupation: _____

Reason for your visit today:

_____

_____

Thank You for taking the time to complete this form.