

### Medical History Questionnaire

Patient Name: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Soc. Sec \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_ Gender: (please circle) male female

Home Phone # \_\_\_\_\_ Cell# \_\_\_\_\_ Work # \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

#### Medical History: (please circle yes if there is a current diagnosis of the following)

Amblyopia (lazy eye)	No	Yes	Glaucoma	No	Yes	Liver Disease	No	Yes
Asthma	No	Yes	Hearing Loss	No	Yes	Lung Disease	No	Yes
Arthritis	No	Yes	Heart Disease	No	Yes	Lupus	No	Yes
Bleeding Disorder	No	Yes	High Blood Pressure	No	Yes	Anxiety	No	Yes
Cataracts	No	Yes	Hepatitis	No	Yes	Macular Degeneration	No	Yes
Diabetes	No	Yes	HIV /AIDS	No	Yes	Migraines	No	Yes
High Cholesterol	No	Yes	Multiple Sclerosis	No	Yes	Stroke	No	Yes
Kidney Disease	No	Yes	Cancer	No	Yes	Thyroid Disease	No	Yes
Environmental Allergies	No	Yes	Type: _____			Other: _____		
Depression	No	Yes	When: _____					

Past Surgeries including Eye Surgeries (please note year): \_\_\_\_\_

#### Current Medications:(include dosage if known)

 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Medication Allergies: No Yes (if yes, list below)

 \_\_\_\_\_ reaction: \_\_\_\_\_  
 \_\_\_\_\_ reaction: \_\_\_\_\_  
 \_\_\_\_\_ reaction: \_\_\_\_\_

#### Latex allergy: No Yes

#### Fill out only if the patient is a CHILD under 5 years of age:

 Current Weight: \_\_\_\_\_  
 Birth Weight: \_\_\_\_ lbs. \_\_\_\_ ozs. or \_\_\_\_ gms  
 Premature at birth No Yes If yes, born at \_\_\_\_ weeks  
 Was delivery by Cesarean Section: No Yes

 Family History of eye crossing No Yes  
 ADHD/ADD No Yes  
 Household Smoker No Yes  
 Developmental Delay No Yes

#### Family History: (please check all that apply)

 Amblyopia(lazy eye) Mother Father Sibling Grandparent  
 Crossing eyes Mother Father Sibling Grandparent  
 Cancer Mother Father Sibling Grandparent  
 Glaucoma Mother Father Sibling Grandparent  
 Diabetes Mother Father Sibling Grandparent

 Retinal Detachment Mother Father Sibling Grandparent  
 Retinitis Pigmentosa Mother Father Sibling Grandparent  
 Macular Degeneration Mother Father Sibling Grandparent  
 Heart Disease Mother Father Sibling Grandparent  
 High Blood Pressure Mother Father Sibling Grandparent

#### Social History: (please circle)

 Alcohol Usage No Socially Moderately Heavy  
 Cigarette Smoking No Yes Quit (when) \_\_\_\_\_

Occupation: \_\_\_\_\_

#### Review of Systems: (Please circle all symptoms which the patient has currently, or has had recently. Circle No if symptom has not occurred. General

(ex: unintentional weight change)	No	Yes	Ear, Nose, Throat (ex: hearing loss, snoring, dizziness)	No	Yes
Cardiovascular: (ex: chest pain, irregular heartbeat)	No	Yes	Respiratory: (ex: wheezing, shortness of breath)	No	Yes
Brain/Nervous System: (ex: numbness, seizures)	No	Yes	Blood/ Lymph Nodes: (ex: excessive bleeding, bruising)	No	Yes
Gastrointestinal: (ex: reflux, nausea, vomiting)	No	Yes	Allergies: (ex: hives, severe reaction to insect bites)	No	Yes
Psychiatric: (ex: anxiety, depression)	No	Yes	Skin: (ex: masses, lesions)	No	Yes
Bone, Joint, Muscle (ex: pain, arthritis, cramping)	No	Yes	Endocrine: (ex: thyroid dysfunction)	No	Yes