

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Birth Date: _____ Age: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Sex: ___ Male ___ Female ___ Other _____ Decline to answer
Race: _____ Ethnicity: ___ Hispanic/Latino ___ Non-Hispanic/Non-Latino Other _____
Language: ___ English ___ Spanish ___ Hmong Other (specify) _____
Who lives in your household? _____
Present Occupation: _____
Name of Doctor referring you: _____ Clinic: _____
Name of Primary Care Physician: _____ Clinic: _____
Pharmacy: _____ Location: _____

MEDICAL HISTORY: Please circle all major illnesses.

Anxiety	COPD	Hypertension	Lymphoma
Arthritis / Rheumatoid	Coronary Artery Disease	HIV/AIDS	Prostate Cancer
Asthma	Depression	High Cholesterol	Radiation Treatment
Atrial Fibrillation	Diabetes	Hyperthyroidism	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroidism	Stroke
Breast Cancer	Hearing Loss	Leukemia	Other _____
Colon Cancer	Hepatitis	Lung Cancer	_____

List all major injuries: _____

List all surgical procedures excluding the eye: _____

EYE HISTORY: Please circle Y-YES or N-NO:

Y N Pain	Y N Dryness	Y N Tearing	Y N Irritation
Y N Itching	Y N Blurry Vision	Y N Redness	Y N Floaters
Y N Distortion	Y N Light Flashes	Y N Double Vision	Y N Light Sensitivity
Y N Halos around light	Y N Lazy Eye	Y N Glare	Y N Loss of Vision

Other (please describe): _____

Previous eye diagnosis: _____

Previous eye injuries or surgeries: _____

Do you wear glasses? Y N If yes, how old are they? _____

Do you wear contacts? Y N If yes; How long? _____ **What brand?** _____ **Power:** _____

FAMILY HISTORY: Please check all that apply

Please circle any blood related family members who have/had any of the following.

F – Father M – Mother B – Brother S – Sister A – Aunt U – Uncle GF – Grandfather GM - Grandmother

Diabetes	F M B S A U GF GM	Macular Degeneration	F M B S A U GF GM
Glaucoma	F M B S A U GF GM	Thyroid Disease	F M B S A U GF GM
Cataract	F M B S A U GF GM	Retinal Detachment	F M B S A U GF GM
Blindness	F M B S A U GF GM	Amblyopia/Strabismus	F M B S A U GF GM
Arthritis	F M B S A U GF GM	Heart Problems	F M B S A U GF GM
Cancer	F M B S A U GF GM	High Blood Pressure	F M B S A U GF GM

(Type) _____

Other (please describe) _____

SOCIAL HISTORY

Do you smoke? YES NO If yes, how much? _____ How long? _____ Never Smoked _____

Are you a former smoker? YES When did you quit? _____

Do you drink alcohol? YES NO If yes, how often? _____

Do you drive? YES NO Please check all that apply: Daytime driving Night driving

REVIEW OF SYSTEMS

Do you currently have any symptoms/conditions in the following areas, even if controlled by medication?

If yes, please circle all that apply:

Fever Unexpected Weight Loss	Stuffy Sinuses Sore Throat Cough Trouble Swallowing	High Blood Pressure Chest Pain	Congestion Wheezing Shortness of Breath
Stomach Pain Diarrhea Urinary Frequency	Joint Pain Muscle Pain Arthritis	Rash Changing skin lesions Skin Disease/Disorder	Headache Stroke Migraine Numb/tingling hands/feet
Anxiety Depression Insomnia	Diabetes- On insulin? Y / N -How long? _____ Thyroid Abnormalities	Easy Bleeding/Bruising Anemia	Seasonal Allergies Hay Fever

ALLERGIES

No known drug allergies

Please list any prescription or non-prescription medications that you are allergic to: _____

Please list any allergies other than to medications: _____

IMMUNIZATIONS (Please check one)

Flu Vaccination - Yes No-Allergic No-Refused No-Other Reason: _____

Pneumonia Vaccination - Yes No

Covid-19 Vaccination - Yes No

In case of emergency, whom may we contact?

Name _____ Relationship _____ Phone _____

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