MD Eye Care, L.L.C. MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Date:_____

Height:____ Weight: _____ Sex: Male / Female Primary Care Physician: _____

CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**NONE**
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, colon, leukemia, lung, lymphoma, skin, prostrate , other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List Last Eye Exam, All Eye Surgeries, & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no		Heart Disease	yes	no	
Macular Degeneration	yes	no		Hypertension	yes	no	
Blindness	yes	no		Stroke	yes	no	
Retinal Disorders	yes	no		Thyroid Disease	yes	no	
Cataracts	yes	no		Arthritis	yes	no	
Glaucoma	yes	no		Cancer	yes	no	
Diabetes	yes	no		Type of Cancer: _____			

Do you wear Contact Lens?_____ If so, what brand?_____

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FAMILY MEDICAL HISTORY CONTINUED:

Is mother deceased? Y / N If yes- cause of death?________________________ Age at death?_______
Is father deceased? Y / N If yes- cause of death?________________________ Age at death?_______

SOCIAL HISTORY:

(Circle:) Student Homemaker Employed Retired (Circle:) Single Married Separated Divorced Widowed Domestic Partner

Do you use Tobacco? Yes / No Never Former Current (light) Current (heavy)

Do you use Alcohol? Yes / No Less than 1 daily 1-2 drinks daily 3 or more drinks daily

Substance Abuse? Yes / No Drug Use IV Drug Use

LIST ANY DRUG ALLERGIES: ____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

REVIEWED:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

Staff	*Date*

Name and Location of Pharmacy:_____________________________ **Phone Number of Pharmacy:**_____________________