Medical History Questionnaire

The Independent Practices of RALEIGH OPHTHALMOLOGY

Patient Name: _____
Date of Birth: _____
Gender: M F

Referring Physician: _____
Primary Care Physician: _____ **Visit Date:** _____
Pharmacy Name: _____ **Pharmacy Phone:** _____
Pharmacy Address: _____

Visual Function Questions *Please indicate if you are experiencing any difficulty with the following:*

Visual Function/Problems	Yes/No	Visual Function/Problems	Yes/No
*Reading small print (newspaper, book)	☐ Yes ☐ No	*Difficulty reading traffic signs, street signs	☐ Yes ☐ No
*Glare/Halo	☐ Yes ☐ No	*Difficulty performing fine handiwork	☐ Yes ☐ No
*Dry, red, gritty and/or itchy feeling to the eyes	☐ Yes ☐ No	*Difficulty seeing the TV	☐ Yes ☐ No
*Difficulty driving on bright sunny days	☐ Yes ☐ No	*Difficulty driving at night	☐ Yes ☐ No
*Difficulty seeing steps, stairs or curbs	☐ Yes ☐ No	*Are you satisfied with your current vision?	☐ Yes ☐ No

**Any other visual function problems? If so, please describe:
_____

Review of Systems: *Please check any problems you are **currently** experiencing*

Constitutional
☐ Fatigue
☐ Fever
☐ Other _____

Cardiovascular
☐ Chest Pain
☐ Irregular Heartbeat
☐ Other _____

Metabolic/Endocrine
☐ Cold Intolerance
☐ Heat Intolerance
☐ Other _____

Integumentary
☐ Hives
☐ Rash
☐ Other _____

HEENT
☐ Bulging Eyes
☐ Hearing Loss
☐ Sinus Problems
☐ Other_____

Gastrointestinal
☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Gas
☐ Other _____

Neurological
☐ Balance Disturbances
☐ Headache
☐ Memory Difficulty
☐ Other _____

Musculoskeletal
☐ Back Pain
☐ Joint Stiffness
☐ Muscle Weakness
☐ Other _____

Respiratory
☐ Asthma
☐ Emphysema
☐ Other _____

Genitourinary
☐ Blood in Urine
☐ Pain w/ Urination
☐ Other _____

Psychiatric
☐ Depressed Mood
☐ Irritability
☐ Other _____

Hematologic/Lymphatic
☐ Bleeding
☐ Bruising
☐ Tender Lymph Nodes
☐ Other _____

Immunologic
☐ Environmental Allergies
☐ Food Allergies
☐ Seasonal Allergies
☐ Other _____

Visual Aids:
Do you wear Glasses? ☐ Yes ☐ No
Do you wear Contact Lenses? ☐ Yes ☐ No

Other:
Current Occupation:_____ Do you drive? ☐ Yes ☐ No
Living Arrangements:
☐ Independent ☐ Nursing home ☐ Family ☐ Rehabilitation

Oral/Injected Medications: *Please list all medications you currently take by mouth or inject*

Medication	Dose	Frequency	Medication	Dose	Frequency

☐ Check here if you ***do not*** take any medications

Name: _____ **DOB** _____

Ocular Medications: *Please list all **ocular (eye)** medications you currently use*

Medication	Dose	Frequency	Medication	Dose	Frequency

☐ Check here if you ***do not*** use any drops for your eyes

Allergies: *Please list all medication allergies & reactions*

Allergy	Reaction	Allergy	Reaction

History of Latex Allergy? ☐ Yes ☐ No **Have you or any family member(s) had an anesthesia reaction?** ☐ Yes ☐ No

☐ Check here if you ***do not*** have any allergies/reactions

Ocular History:

Previous Eye diseases/injury/surgeries	Which Eye?	Treatment/Surgery	When?

Medical History: *Please indicate conditions you currently have or have ever had*

Name of Condition	YES/NO	Name of Condition	YES/NO
Diabetes (Type_____) Date Diagnosed? _____	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Heart Disease Surgery? _____	☐ Yes ☐ No When? _____	Females: Pregnant? Nursing?	☐ Yes ☐ No ☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Kidney Failure Dialysis? ☐ Yes ☐ No	☐ Yes ☐ No When? _____	Cancer Tumor Type? _____	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Psychiatric Issues Diagnosis? _____	☐ Yes ☐ No

Family History: *Please indicate M= mother, F= father, S= sibling (brother/sister), GP= grandparent*

Diagnosis	Relationship	Diagnosis	Relationship
High Blood Pressure ☐ Yes ☐ No		Macular Degeneration ☐ Yes ☐ No	
Cancer ☐ Yes ☐ No		Retinal Detachment ☐ Yes ☐ No	
Glaucoma ☐ Yes ☐ No		Diabetes ☐ Yes ☐ No	
Blindness ☐ Yes ☐ No		Heart Problems ☐ Yes ☐ No	

**Other family-related eye/medical problems: *Please specify*_____

Social History:

Tobacco/tobacco product use ☐ Current ☐ Former ☐ No

If current/former, please specify type: ☐ Cigarette ☐ Cigar ☐ Chewing ☐ Pipe ☐ Smokeless

Units/Day: _____ Years Used: _____ Year Quit *(if applicable):* _____

Alcohol Use: ☐ Yes ☐ No ☐ Formerly

If yes/formerly, please specify frequency: ☐ Daily ☐ Moderately ☐ Occasionally ☐ Socially ☐ Rarely

Patient Signature: _____ **Date:** _____