ASSOCIATED EYE CARE
Medical History Questionnaire

Patient name: _____ **Date:** _____
Primary care provider name and address: _____
_____

In a few words, what brings you in today? _____
_____

SINCE THIS PROBLEM BEGAN, HAVE YOU HAD ANY OF THE FOLLOWING?

Seasonal allergies	___	Vomiting	___	Headaches	___
Hay fever	___	Stomach ulcers	___	Migraines	___
		Diarrhea	___	Paralysis	___
Chest pain	___	Blood in stool	___	Joint aches	___
Congestive heart failure	___			Muscle aches	___
Irregular heart rhythm	___	Genital ulcers	___		
		Urinary or genital discharge	___	Cough	___
Fever	___	Kidney stones	___	Bronchitis	___
Weight loss (unintended)	___	Blood in urine	___	Shortness of breath	___
Rash	___			Asthma attack	___
Skin problems	___	Sinus problems	___	Wheezing	___
		Post-nasal drip	___		
		Runny nose	___		
		Dry mouth	___		
		Hearing loss	___		

Please list any other symptoms not listed above: _____
_____

EYE HISTORY

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	Yes	Condition	Yes
Dry eyes	___	Retinal detachment	___
Macular degeneration	___	Keratoconus	___
Glaucoma	___	Lazy/crossed eye	___
Cataracts	___	Uveitis/iritis	___

Do you wear glasses? ☐ Yes ☐ No **For reading, distance, or both?** _____
How old are your eyeglasses? _____
Have you ever had eye surgery, including LASIK or other refractive surgeries, or an eye injury? ☐ Yes ☐ No
If yes, please list your eye surgeries and/or injuries and their dates: _____
_____
_____

Do you wear contact lenses? ☐ Yes ☐ No **Do you sleep in them?** ☐ Yes ☐ No
What kind are they? _____ **How old are they?** _____

Please complete opposite side.

MEDICAL HISTORY

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	Yes	Condition	Yes	Condition	Yes
High blood pressure	___	Type 1 diabetes	___	Sleep apnea	___
Heart problems	___	Type 2 diabetes	___	Blood disorder	___
Osteoarthritis	___	LDL	___	Skin problems	___
Rheumatoid arthritis	___	Stomach ulcers	___	Autoimmune disease	___
COPD/emphysema	___	Cancer	___	Migraines	___
Asthma	___	Kidney problems	___	Tuberculosis	___
Stroke	___	Stroke	___	HIV	___
Thyroid problems	___	Migraines	___		

If you have diabetes, what was your last hemoglobin A1c? ____ **What is your usual fasting blood sugar?** ___

Please list any other health problems not listed above: _____

_____

Please list any surgeries you have had and their dates: _____

_____

Have you had a flu shot this year? ☐ Yes ☐ No, for medical reasons ☐ No, for non-medical reasons

CURRENT MEDICATIONS

Please list all medications you currently take, including any supplements: _____

_____

_____

ALLERGIES AND MEDICATION INTOLERANCES

Please list any allergies and medication intolerances, as well as the reactions you experience: _____

_____

_____

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No

If yes, what and how much do you smoke? _____

At what age did you start smoking? _____

If no, are you a former smoker? ☐ Yes ☐ No **At what age did you quit smoking?** _____

Does anyone in your immediate family smoke? ☐ Yes ☐ No **If yes, who?** _____

How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Several times a month ☐ Never

FAMILY MEDICAL HISTORY

Have any of your <u>blood relatives</u> had or been treated for any of the following conditions?

Condition	Yes	Relationship	Condition	Yes	Relationship
High blood pressure	___	_____	Dry eyes	___	_____
Heart problem	___	_____	Macular degeneration	___	_____
Osteoarthritis	___	_____	Glaucoma	___	_____
Rheumatoid arthritis	___	_____	Cataracts	___	_____
Lung problems	___	_____	Retinal detachment	___	_____
Stroke	___	_____	Keratoconus	___	_____
Thyroid problems	___	_____	Lazy/crossed eye	___	_____
Diabetes	___	_____			
High cholesterol	___	_____			
Stomach ulcers	___	_____			
Cancer	___	_____			