

Medical History Questionnaire

LAST NAME _____ MI _____ FIRST NAME _____

DATE _____ AGE _____ WHO REFERRED YOU? _____

1. What is your **OCCUPATION**? _____

2. What is the **MAIN REASON** for your visit? _____

3. Please list all known **ALLERGIES** to medications or LATEX: None See attached list
MEDICATION REACTION

4. Please list any **EYE PROBLEMS** you have or have had: None See attached list
 (For example: glaucoma, macular degeneration, cataract, lazy eye, strabismus, eye trauma, prism glasses, etc....)

5. Please list any **EYE SURGERY** you have had in the past: None See attached list
 (For example: glaucoma, cataract, retina, laser surgery, eyelid surgery, injections, etc....)

6. Please list all your **EYE DROPS**: None See attached list
NAME OF EYE DROP WHICH EYE(S) HOW OFTEN

7. Please list any **MEDICAL PROBLEMS** you have or have had: None See attached list
 (For example: high blood pressure, diabetes, heart disease, arthritis, etc.)

8. Please list any **SURGERIES** you have had: None See attached list

9. Please list all your **MEDICATIONS AND SUPPLEMENTS**: None See attached list

<u>NAME OF MEDICATION</u>	<u>STRENGTH</u>	<u>FREQUENCY</u>	<u>NAME OF MEDICATION</u>	<u>STRENGTH</u>	<u>FREQUENCY</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

10. Does or did anyone in your **FAMILY** ever have any of the following?

Glaucoma?	___ Yes	___ No	Who? _____
Macular Degeneration?	___ Yes	___ No	Who? _____
Blindness?	___ Yes	___ No	Who? _____
Diabetes?	___ Yes	___ No	Who? _____

11. What is your **SMOKING** history?

Current Every Day Smoker <input type="checkbox"/>	Current Some Day Smoker <input type="checkbox"/>	Former Smoker, Quit: _____ <input type="checkbox"/>	Never Smoked <input type="checkbox"/>
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South Bay Ophthalmology, Inc.

Edward J. Saub, M.D.
Eye Physician and Surgeon

Optical Shop

12. Describe your **ALCOHOL** consumption:

<i>Never</i> <input type="checkbox"/>	<i>Rare</i> <input type="checkbox"/>	<i>On Occasion</i> <input type="checkbox"/>	<i>1 per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail			<i>2 per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail			<i>3 or more per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail		
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13. Circle your **RELATIONSHIP** status? *Single* *Married* *Domestic Partner* *Widowed* *Divorced*

14. What is your **PREFERRED LANGUAGE**? _____

15. Of the following choices, **WHICH BEST DESCRIBES YOU?** Please check one.

<i>American Indian/Alaska Native</i> <input type="checkbox"/>	<i>Asian</i> <input type="checkbox"/>	<i>Black/African American</i> <input type="checkbox"/>	<i>Native Hawaiian/Pacific Islander</i> <input type="checkbox"/>	<i>Hispanic/Latino</i> <input type="checkbox"/>	<i>All Others</i> <input type="checkbox"/>
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16. Do you wear **GLASSES**? ___ Yes ___ No

17. Do you wear **CONTACT LENSES**? ___ Yes ___ No *How often?* _____ *Monovision?* Y / N *Near Eye:* R / L

What brand? _____

What power? Right: _____ Left: _____ *What base curve?* Right: _____ Left: _____

18. Please indicate whether or not you **CURRENTLY HAVE** any of the following symptoms or conditions listed:

Eyes	Y	N	Respiratory	Y	N	Blood/Lymph	Y	N
Previous Surgery			Cough			Easy Bruising		
Contact Lens			Congestion			Gums Bleed Easily		
Pain			Wheezing			Prolonged Bleeding		
Double Vision			Asthma			Heavy Aspirin Use		
Glaucoma			Tuberculosis			Autoimmune Disorder		
Cataracts			Sinusitis			Lymphoma or Leukemia		
Macular Degeneration								
Dry Eyes								
Flashes			Gastrointestinal			Musculoskeletal		
Floaters			Heartburn			Stiffness		
			Nausea/Vomiting			Arthritis		
Ear, Nose, Throat			Jaundice/Hepatitis			Joint Pain/Swelling		
Hard of Hearing			Dental Problems			Low Back Pain		
Ringing in Ears			Crohn's Disease or Colitis					
Vertigo						Skin		
Snoring or Sleep Apnea			Genito-Urinary			Rash/Sores		
Excessive Dry Mouth			Pain/Difficulty			Lesions		
			Blood in Urine			Hives/Eczema		
Cardiovascular			History of Kidney Stones					
Chest Pain			History of STDs			Neurological		
Dizziness			Kidney Disease			Seizures		
Fainting Spells						Weakness/Paralysis		
Shortness of Breath			Psychiatric			Numbness		
Irregular Heart Beat			Anxiety/Depression			Tremors		
Difficulty Lying Flat			Mood Swings			Headache or Migraine		
Raynaud's Syndrome			Difficulty Sleeping			Multiple Sclerosis		
Stroke								
			Endocrine			Immunologic		
Constitutional			Increased Thirst			Hives		
Fatigue/Weakness			Increased Hunger			Itching		
Fever			Increased Urination			Runny Nose		
Weight Gain/Loss			Increased Sweating			Sinus Pressure		
Night Sweats			Fingernail Changes			HIV		