Eye Medical Clinic, 220 Meridian Ave, San Jose CA 95126

# MEDICAL HISTORY QUESTIONNAIRE

NAME _____ PRIMARY CARE PHYSICIAN _____

DATE ___ /___ / 200__ REFERRED TO OUR OFFICE BY _____

D.O.B ___ /___ / ___ AGE _____ YOUR OCCUPATION _____

## DO YOU USE...?

| | | | | |
|---|---|---|---|---|
| ALCOHOL | ☐ NEVER | ☐ SOCIALLY | ☐ FREQUENTLY | ☐ QUIT |
| TOBACCO | ☐ NEVER | ☐ SOCIALLY | ☐ FREQUENTLY | ☐ QUIT |
| DRUGS | ☐ NEVER | ☐ SOCIALLY | ☐ FREQUENTLY | ☐ QUIT |

| | | | | |
|---|---|---|---|---|
| GLASSES | ☐ DISTANCE | ☐ NEAR | ☐ BIFOCAL/PROG | ☐ SUN |
| CONTACTS | ☐ DISTANCE | ☐ MONO | ☐ BIFOCAL/PROG | |

## DO YOU TAKE ANY OF THESE DRUGS?

- ☐ TAMOXIFEN
- ☐ CHLOROQUINE
- ☐ FLOMAX (TAMSULOSIN)
- ☐ MYAMBUTOL (ETHAMBUTOL)
- ☐ PREDNISONE (CORTICOSTEROIDS)
- ☐ PLAQUENIL (HYDROXYCHLOROQUINE)
- ☐ MELLARIL (PHENOTHIAZINE)
- ☐ CORDARONE (AMIODARONE)

## WHAT KIND OF EYE PROBLEMS HAVE YOU HAD?

1 ☐ GLAUCOMA
2 ☐ DIABETIC EYE DISEASE
3 ☐ MACULAR DEGENERATION
4 ☐ CATARACT
5 ☐ DRY EYE
6 ☐ THYROID EYE DISEASE
7 ☐ LAZY EYE
8 ☐ CROSSED EYE
9 ☐ RETINAL DETACHMENT
10 ☐ BLEEDING IN THE EYE
11 ☐ INJURY TO THE EYE
12 ☐ LASER TREATMENT
13 ☐ BLOCKED TEAR DUCT
14 ☐ (LIST ON OTHER SIDE)

## WHAT ABOUT YOUR MEDICAL HISTORY?

15 ☐ DIABETES
16 ☐ THYROID DISEASE
17 ☐ HEART DISEASE
18 ☐ ASTHMA
19 ☐ CANCER
20 ☐ HIGH BLOOD PRESSURE
21 ☐ STROKE
22 ☐ ARTHRITIS
23 ☐ PSYCHIATRIC DISORDER
24 ☐ AUTOIMMUNE DISEASE
25 ☐ TUBERCULOSIS
26 ☐ PROSTATE ENLARGEMENT
27 ☐ HIV
28 ☐ (LIST ON OTHER SIDE)

## DO YOU EXPERIENCE...?

29 ☐ CHEST PAIN
30 ☐ SHORTNESS OF BREATH
31 ☐ REGULAR COUGHING
32 ☐ COUGHING UP BLOOD
33 ☐ FREQUENT URINATION
34 ☐ BLOODY URINE OR STOOL
35 ☐ RINGING IN EARS
36 ☐ LOSS OF BALANCE
37 ☐ UNUSUAL WEIGHT LOSS
38 ☐ FREQUENT HEADACHES
39 ☐ BLEEDING PROBLEM
40 ☐ SWOLLEN GLANDS
41 ☐ DIZZINESS
42 ☐ PAIN

## DO THESE PROBLEMS RUN IN YOUR FAMILY?

43 ☐ GLAUCOMA
44 ☐ MACULAR DEGENERATION
45 ☐ CATARACT
46 ☐ RETINAL DETACHMENT
47 ☐ RETINITIS PIGMENTOSA
48 ☐ LAZY EYE (AMBLYOPIA)
49 ☐ STROKE / HEART ATTACK
50 ☐ DIABETES
51 ☐ CANCER
52 ☐ HEART DISEASE

## CURRENT MEDICATION

IF YOU HAVE A PRINTED LIST, ATTACH IT TO THIS FORM

## PAST SURGERY / HOSPITALIZATION

DATE OPERATION / PROBLEM

## DRUG ALLERGIES

NONE ☐

**USE REVERSE SIDE TO EXPLAIN ANSWERS**