Medical History Questionnaire

Plessen Ophthalmology Comprehensive Eye Care

Name:_____ Date:___/___/_____ Birth Date:___/___/_____

Last Medical Exam:___/___/_____ Name of Medical Doctor:_____ Dr.'s Phone:_____

Name of Pharmacy and Location:_____ Pharmacy Number:_____

Last Eye Exam:___/___/_____ Name of Eye Care Provider:_____

Past Eye/Medical History

Allergies: ☐ None ☐ Yes: (list)_____

Have you ever had any eye injuries? ☐ No ☐ Yes: (list)_____

Do you have any eye diseases? Please check all that apply. ☐ Macular Degeneration ☐ Cataract ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Dry Eye Syndrome ☐ Other: (list)_____

Have you ever had any eye surgeries? ☐ No ☐ Yes: (list)_____

Do you currently use any eye medications? ☐ No ☐ Yes: (list)_____

Do you have any medical conditions? Please check all that apply. ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid Disorder ☐ Autoimmune Disease (name:_____)

Please list any additional medical conditions. _____

_____

_____

List all major surgeries:_____

_____

List all prescription and over-the-counter medications you are currently taking: (Additional page available if needed)

Medication:	Reason for taking:	Dose:	Amount/Frequency:

Are you pregnant or nursing? ☐ No ☐ Yes

Check if you have ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ TB

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other

Family History: (Check all that apply to your blood relatives and then describe below)

☐ Diabetes ☐ Stroke ☐ Blindness ☐ Macular Degeneration ☐ Arthritis
☐ Cancer ☐ TB ☐ Cataracts ☐ Retinal Disease ☐ Lazy Eye
☐ Heart Disease ☐ Kidney Disease ☐ Glaucoma ☐ High Blood Pressure Other:_____

Condition:_____ Relation:_____ Living ☐ Deceased ☐ Approximate Age:_____
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Please turn this form over and complete side two

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Social History:

Smoking Status: (Check one) ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Never smoked ☐ Smoker, current status unknown
☐ Unknown if ever smoked

If smoker: How much?_____ How long?_____When quit? _____

Alcohol Use: ☐ No ☐ Yes: Type?_____ How much? _____

Drugs: ☐ No ☐ Yes: Type?_____How much? _____How long?_____When quit? _____

Review of Systems: Please comment on any "Yes" answers in the space provided below.

Eyes	**Respiratory**	**Blood/Lymphnodes**
Previous Surgery ☐ Yes ☐ No	Cough ☐ Yes ☐ No	Easy Bruising ☐ Yes ☐ No
Contact Lens Use ☐ Yes ☐ No	Congestion ☐ Yes ☐ No	Gums Bleed Easily ☐ Yes ☐ No
Pain ☐ Yes ☐ No	Wheezing ☐ Yes ☐ No	Prolonged Bleeding ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Heavy Aspirin Use ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No	**Gastrointestinal**	**Musculoskeletal**
Cataracts ☐ Yes ☐ No	Heartburn ☐ Yes ☐ No	Stiffness ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No	Nausea/Vomiting ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No
Dry Eyes ☐ Yes ☐ No	Jaundice/Hepatitis ☐ Yes ☐ No	Joint Pain/Swelling ☐ Yes ☐ No
Flashes ☐ Yes ☐ No	**Genito-Urinary**	**Skin**
Floaters ☐ Yes ☐ No	Pain/Difficulty Urinating ☐ Yes ☐ No	Rash/Sores ☐ Yes ☐ No
Ear, Nose and Throat	Blood in Urine ☐ Yes ☐ No	Lesions ☐ Yes ☐ No
Hard of Hearing ☐ Yes ☐ No	History of Kidney Stones ☐ Yes ☐ No	Hives/Eczema ☐ Yes ☐ No
Ringing in Ears ☐ Yes ☐ No	History of STD's ☐ Yes ☐ No	**Neurological**
Vertigo ☐ Yes ☐ No	**Psychiatric**	Seizures ☐ Yes ☐ No
Cardiovascular	Anxiety/Depression ☐ Yes ☐ No	Weakness/Paralysis ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No	Mood Swings ☐ Yes ☐ No	Numbness ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No	Difficulty Sleeping ☐ Yes ☐ No	Tremors ☐ Yes ☐ No
Fainting Spells ☐ Yes ☐ No	**Endocrine**	Headaches ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No	Increased Thirst ☐ Yes ☐ No	**Immunologic**
Irregular Heart Beat ☐ Yes ☐ No	Increased Hunger ☐ Yes ☐ No	Hives ☐ Yes ☐ No
Difficulty Lying Flat ☐ Yes ☐ No	Increased Urination ☐ Yes ☐ No	Itching ☐ Yes ☐ No
Constitutional	Increased Sweating ☐ Yes ☐ No	Runny Nose ☐ Yes ☐ No
Fatigue/Weakness ☐ Yes ☐ No	Fingernail Changes ☐ Yes ☐ No	Sinus Pressure ☐ Yes ☐ No
Fever ☐ Yes ☐ No		Immunosuppress ☐ Yes ☐ No
Weight Gain/Loss ☐ Yes ☐ No		
Jaw Pain When Chewing ☐ Yes ☐ No		
Scalp Tenderness ☐ Yes ☐ No		

V1.5

Explanations:

Doctor's Signature

Review Date