Main Office: 216 Corder Road – Warner Robins, GA 31088
Phone (478) 923-5872 Fax (478) 929-6266

MEDICAL HISTORY QUESTIONNAIRE

Full Name: ____ Nickname: __________________

Date of Birth: ____/____/______

Primary Care Physician: _______________________________

Referring /Specialty Dr.________________________

Pharmacy: ______________________________Location (street & city) ____________________

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies: Reaction Severity

_________________________ _____________________________ mild / moderate / severe
_________________________ _____________________________ mild / moderate / severe
_________________________ _____________________________ mild / moderate / severe
_________________________ _____________________________ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Amblyopia (Lazy eye) □ Aphakia □ Astigmatism
□ Cataracts □ Diabetic Retinopathy □ Dry Eyes □ Glaucoma
□ Hyperopia (Far sighted) □ Iritis □ Keratoconus □ Macular Degeneration
□ Myopia (Near sighted) □ Optic Neuritis □ Retinal Detachment
Other (please list) ____

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Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Cataract Surgery □ Corneal Transplant □ Eye lid surgery
□ Eye muscle surgery □ Foreign Body Removal □ Glaucoma surgery □ LASIK/LASEK
□ Punctal Plugs □ Retinal Laser Surgery □ RK □ PRK
□ Vitrectomy

Other____

Current Eye Medications: (Please list)

____
____
____
____

Systemic Illnesses:

□ No history of illnesses
□ AIDS □Anemia □Arrhythmia □ Arthritis
□ Cancer □ Congestive heart failure □ COPD □ Diabetes
□ Eczema □ Fibromyalgia □ Headache □ Hearing loss
□ Hepatitis A / B / C □ High blood pressure □ High Cholesterol □ Kidney disease/ stones
□ Lung disease/ Asthma □ Lupus □ Migraine □ MRSA
□ Multiple Sclerosis □ Rheumatoid arthritis □ Sjogrens □ Stroke
□ Syphilis

Other____

Past Operations/ General Surgeries: (Please list)

____
____
____
____

Current Systemic Medications: (Please list)

____
____
____
____
____
____

PLEASE COMPLETE SECOND SHEET

Family History:

□ Diabetes	□ Stroke	□ Blindness	□ Macular Degeneration	□ Arthritis
□ Cancer	□ Tuberculosis	□ Cataracts	□ Retinal Disease	□ Lazy Eye
□ Heart Disease	□ Kidney Disease	□ Glaucoma	□ High Blood Pressure	

Other____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ occasional smoker □ former smoker

□ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often? ________________

Recreational Drug Use: □ Yes □ No If yes what and how often? ____________________

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure