CLEARVIEW
EYECARE AND LASER CENTER

Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/____ Height: _____ Weight: _____

Occupation: _____ Gender: _____ Spoken Language: _____

Primary Care Physician Name: _____ Primary Care Physician Phone #: _____

PLEASE MARK ALL THAT APPLY.

PAST OCULAR HISTORY:

- □ **NONE**
- □ Amblyopia (Lazy Eye)
- □ Astigmatism
- □ Cataracts
- □ Diabetic Retinopathy
- □ Dry Eyes
- □ Glasses/Contact lenses
- □ Glaucoma
- □ Hyperopia (far sighted)
- □ Iritis
- □ Keratoconus
- □ Macular Degeneration
- □ Myopia (Near sighted)
- □ Optic Neuritis
- □ Ret. Detachment/Tear
- □ Other:_____

OCULAR SURGERIES (indicate Right or Left Eye):

- □ **NONE**
- □ Blepharoplasty (eyelids)
- □ Cataract Surgery
- □ Corneal Transplant
- □ Retinal Laser Surgery
- □ LASIK
- □ PRK
- □ RK
- □ Vitrectomy
- □ Strabismus Surgery (eye muscle surgery)
- □ Laser Capsulotomy (YAG)
- □ Peripheral Iridotomy (glaucoma surgery)
- □ Other:_____

INFECTIONS – Past or Present (indicate time period diagnosed next to each infection checked):

- □ **NONE**
- □ Hepatitis A / B / C _____
- □ Herpes/Shingles _____
- □ HIV / AIDS _____
- □ Meningitis _____
- □ MRSA/Staph _____
- □ Tuberculosis (TB) _____
- □ Wound Infection _____
- □ Other:_____

ALLERGIES:

Are you allergic to any medications? Yes / No If yes, please list medication allergy and reaction below.

Allergies:	**Reaction :**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GENERAL SURGERIES / OPERATIONS: (Please list all surgeries. You may continue on the back side of this page if needed) □ **NONE**

_____

_____

_____

_____

HOSPITALIZATION:

When was the last time you were in the hospital? _____ Reason?_____

ANESTHESIA:

Have you ever had any problems with anesthesia? Yes / No If yes, what was the reaction?_____

SOCIAL HISTORY: (Please mark all that apply)

□ Pregnant / Nursing

Tobacco: □ Never smoked □ Current smoker □ Former smoker # of smoking years?_____ Date quit?_____

Alcohol: □ None □ Former Alcohol Abuse □ Current Alcohol use Frequency: Daily / Weekly / Monthly / Yearly Quantity?_____

Recreational Drug Use: □ None □ Former Drug Use □ Current Recreational Drug Use Drug?_____

Frequency: Daily / Weekly / Monthly / Yearly

REVIEW OF SYSTEMS: (Please mark all that apply)

Integumentary (Skin) □ **NONE**
- □ Skin Cancer
- □ Eczema / Rosacea
- □ Psoriasis
- □ Other:_____

Ears, Nose, Throat □ **NONE**
- □ Hearing Loss
- □ Vertigo
- □ Other:_____

Respiratory □ **NONE**

Treating Dr. _____

Phone: _____
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ COPD
- □ Lung Cancer
- □ Tuberculosis
- □ Sleep Apnea/CPAP
- □ O2 use Liters?_____
- □ Other:_____

Gastrointestinal □ **NONE**
- □ Colon Cancer
- □ Liver Cancer
- □ Ulcers
- □ Reflux/Heartburn/GERD
- □ Crohn's Disease
- □ Other:_____

Endocrine □ **NONE**
- □ Diabetes Oral/Insulin/Diet
- □ Thyroid Disease
- □ Graves' Disease
- □ Pituitary Disorder
- □ Other:_____

Hematologic/Lymphatic □**NONE**
- □ AIDS/HIV
- □ Anemia
- □ Bleeding Disorder
- □ Breast Cancer : Right / Left
- □ Hepatitis
- □ Leukemia
- □ Lupus
- □ Lymphatic Cancer
- □ Other:_____

Cardiovascular □ **NONE**

Treating Dr. _____

Phone: _____
- □ High Blood Pressure (HTN)
- □ High Cholesterol
- □ Coronary Artery Disease (CAD)
- □ Congestive Heart Failure(CHF)
- □ Dysrhythmia Type:_____
- □ Pacemaker Date:_____
- □ Angina Date:_____
- □ Murmur
- □ Heart Attack (MI) Date:_____
- □ Bypass Date:_____
- □ Other:_____

Genitourinary □ **NONE**
- □ Kidney Disease
- □ Bladder Infection
- □ Prostate Cancer
- □ Ovarian/Uterine CA
- □ BPH (Enlarged Prostate)
- □ Other:_____

Musculoskeletal □ **NONE**
- □ Rheumatoid Arthritis
- □ Arthritis
- □ Fibro/Polymyalgia
- □ Osteoporosis
- □ Gout
- □ Other:_____

Neurological □ **NONE**

Treating Dr. _____

Phone: _____
- □ Bell's Palsy
- □ Dementia
- □ Alzheimer's
- □ Brain Tumor
- □ Parkinson's
- □ Migraines
- □ Multiple Sclerosis
- □ Seizures
- □ Stroke (CVA) Date: _____
- □ Weakness/Paralysis
- □ Headaches
- □ Dizziness
- □ Tremors
- □ Other:_____

Psychiatric □ **NONE**
- □ Anxiety
- □ Depression
- □ Bipolar Disorder
- □ PTSD
- □ Schizophrenia
- □ Other:_____

I hereby certify that the above information is true to the best of my knowledge.

Signature: _____ Date:_____

MEDICATION LIST

Medication	Dosage(s)	Number of tabs	Route	Times/day

RN Signature/Date:_____

Updated RN Signature/Date:_____