GINSBERG EYE
OPHTHALMOLOGY

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Date of Birth: _____/____/______

Pharmacy: ___________________________ Location: (street & city) __________________________________ Phone: ___________________

Primary Care Physician: ____ Phone: ___________________

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

Ethnicity: □ Hispanic □ Not Hispanic

Allergies:	**Reaction**	**Severity**
___________________________	________________________________	mild / moderate / severe
___________________________	________________________________	mild / moderate / severe
___________________________	________________________________	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Cataracts	□ Iritis/Uveitis	□ Eye Trauma
□ Corneal Problems	□ Scleritis	□ Amblyopia (Lazy eye)
□ Dry Eyes	□ Retinal Detachment	□ Myopia (Near sighted)
□ Keratoconus	□ Macular Degeneration	□ Hyperopia (Far sighted)
□ Fuch's Dystrophy	□ Diabetic Retinopathy	□ Astigmatism
□ Glaucoma	□ Optic Neuritis	□ Herpes Simplex

Other____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**
□ □ Cataract Surgery	□ □ Corneal Transplant	□ □ Vitrectomy
□ □ Laser after Cataract Surgery	□ □ Punctal Plugs	□ □ Glaucoma Laser
□ □ LASIK	□ □ Foreign Body Removal	□ □ Glaucoma Surgery
□ □ PRK	□ □ Blepharoplasty	□ □ Strabismus Surgery
□ □ RK	□ □ Retinal Laser Surgery	

Other____

Current Eye Medications: (Please list)

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

All Other Medications: (Please list)

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

Med: _______________________________ Strength: _____________________________ Dosage: ______________________________

Other Medical History:

□ No history of illnesses

□ Anemia
□ Arrhythmia
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Chicken Pox
□ Congestive Heart Failure
□ COPD
□ Diabetes Type 1
□ Diabetes Type 2
□ Eczema
□ Fibromyalgia
□ Giant Cell Arteritis
□ Headache
□ Hearing Loss
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ High Blood Pressure
□ High Cholesterol
□ Histoplasmosis
□ HIV/ AIDS
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Meningitis
□ Migraine
□ MRSA
□ MS
□ Polymyalgia
□ Psychiatric Disorder
□ Sarcoidosis
□ Skin Cancer
□ Stroke
□ Syphilis
□ Thyroid Disease
□ Toxoplasmosis
□ Wound Infection

Other____

General Surgeries / Operations: (Please list)

____________________ ____________________ ____________________

Family History:

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

Other____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

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

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

Patient Signature: ______________________________ **Date:** ____________________