



GINSBERG EYE

OPHTHALMOLOGY

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date of Birth: ____/____/____

Pharmacy: _____ Location: (street & city) _____ Phone: _____

Local 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

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Eye Trauma |
| <input type="checkbox"/> Corneal Problems | <input type="checkbox"/> Scleritis | <input type="checkbox"/> Amblyopia (Lazy eye) |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Hyperopia (Far sighted) |
| <input type="checkbox"/> Fuch's Dystrophy | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Optic Neuritis | <input type="checkbox"/> Herpes Simplex |

Other _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> <input type="checkbox"/> Laser after Cataract Surgery | <input type="checkbox"/> <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> <input type="checkbox"/> Glaucoma Laser |
| <input type="checkbox"/> <input type="checkbox"/> LASIK | <input type="checkbox"/> <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> <input type="checkbox"/> Glaucoma Surgery |
| <input type="checkbox"/> <input type="checkbox"/> PRK | <input type="checkbox"/> <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> <input type="checkbox"/> Strabismus Surgery |
| <input type="checkbox"/> <input type="checkbox"/> RK | <input type="checkbox"/> <input type="checkbox"/> 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

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

Other _____

General Surgeries / Operations: (Please list)

Family History:

- | | | | |
|------------------------------------|--|---|---------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Retinal Disease | |

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

Respiratory

- Cough
- Congestion
- Wheezing
- Asthma

Blood / Lymph nodes

- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heavy Aspirin Use

Gastrointestinal

- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

Musculoskeletal

- Stiffness
- Arthritis
- Joint Pain / Swelling

Ear, Nose, and Throat

- Hard of Hearing
- Ringing in Ears
- Vertigo

Genito-Urinary

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

Skin

- Rash / Sores
- Lesions
- Hives / Eczema

Cardiovascular

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

Psychiatric

- Anxiety / Depression
- Mood Swings
- Difficulty Sleeping

Neurological

- Seizures
- Weakness / Paralysis
- Numbness
- Tremors

Constitutional

- Fatigue / Weakness
- Fever
- Weight Gain / Loss

Endocrine

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

Immunologic

- Hives
- Itching
- Runny Nose
- Sinus Pressure

Patient Signature: _____ **Date:** _____