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

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