RAND EYE INSTITUTE

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MEDICAL HISTORY QUESTIONNAIRE

Part A

Name _____ Sex ☐ M ☐ F Date of Birth _____ Date _____

Ocular History (glaucoma, cataracts, diabetic retinopathy, etc.)

☐ Glaucoma ☐ Diabetic Retinopathy ☐ Eye Injury ☐ Flashes
☐ Cataract ☐ Macular Degeneration ☐ Dry Eye ☐ Floaters

Other: _____

List all major illnesses or injuries (diabetes, high blood pressure, heart attack, trauma or accidents etc.)

_____

Have you fallen in the last 12 months? ☐YES ☐NO _____

List all surgeries you have had and when this occurred: (please include dates and procedure)

_____

Have you previously or are you currently experiencing any problems in the following areas? If YES, please provide additional information.

GENERAL / CONSTITUTIONAL ☐ YES ☐ NO _____
☐ Fever ☐ Heat Stroke ☐ Weight Loss ☐ Weight Gain ☐ Unusually Tired, etc.

EARS, NOSE, THROAT ☐ YES ☐ NO _____
☐ Hard Of Hearing ☐ Stuffy Nose ☐ Ear Ache ☐ Cough ☐ Dry Mouth, etc.

CARDIOVASCULAR ☐ YES ☐ NO _____
☐ High Blood Pressure ☐ Racing Pulse ☐ Pacemaker ☐ Implantable Defibrillator ☐ Heart Failure, etc.

RESPIRATORY ☐ YES ☐ NO _____
☐ Congestion ☐ Wheezing ☐ Short Of Breath ☐ Tuberculosis, etc.

GASTROINTESTINAL ☐ YES ☐ NO _____
☐ Upset Stomach ☐ Diarrhea ☐ Constipation ☐ Hernia, Ulcers, etc.

GENITAL, KIDNEY, BLADDER ☐ YES ☐ NO _____
☐ Painful Urination ☐ Frequent Urination ☐ Impotence ☐ Yellow Jaundice ☐ Dialysis, etc.

MUSCLES, BONES, JOINTS ☐ YES ☐ NO _____
☐ Fibromyalgia ☐ Joint Pain ☐ Stiffness ☐ Swelling ☐ Cramps ☐ Arthritis, etc.

SKIN ☐ YES ☐ NO _____
☐ Growths ☐ Rash ☐ Moles, etc.

NEUROLOGICAL ☐ YES ☐ NO _____
☐ Numbness ☐ Headache ☐ Seizures ☐ Paralysis, etc.

PSYCHIATRIC ☐ YES ☐ NO _____
☐ Anxiety ☐ Depression ☐ Insomnia

FEMALES Are you pregnant? ☐ YES ☐ NO if YES, due date _____
Nursing? ☐ YES ☐ NO

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MEDICAL HISTORY QUESTIONNAIRE

Part B

ENDOCRINE ☐ YES ☐ NO _____

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Hypothyroid, etc. Treating Doctor's Name: _____

Dr. Phone: _____ Address: _____ Email: _____

BLOOD / LYMPH ☐ YES ☐ NO _____

☐ Bleeding ☐ Cholesterolemia ☐ Anemia ☐ Problems Related to Blood Transfusion, etc.

ALLERGIC / IMMUNOLOGIC ☐ YES ☐ NO _____

☐ Sneezing ☐ Swelling ☐ Redness ☐ Itching ☐ Hives ☐ Lupus, etc.

Other _____

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had the following diseases? (check all that apply)

	Mother	Father	Sister	Brother	Maternal GrandParent		Paternal GrandParent	
Blindness	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Heart Disease	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Keratoconus	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Cataract	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Stroke	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Glaucoma	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Cancer	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Diabetes	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Thyroid Disease	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Hypertension	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father
Macular Degeneration	☐	☐	☐	☐	☐ Mother	☐ Father	☐ Mother	☐ Father

Hereditary or other diseases

_____

SOCIAL HISTORY

Have you ever had a blood transfusion? ☐ YES ☐ NO

Smoking Status:

- ☐ 1) Never Smoker
- ☐ 2) Former Smoker
- ☐ 3) Current Smoker - Everyday Smoker
- ☐ 4) Current Smoker - Someday Smoker

Social History:

- ☐ Non-Alcohol Drinker
- ☐ Social Alcohol Drinker
- ☐ Drinks Alcohol Daily
- ☐ Caffeine User
- ☐ Drug User

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you live alone? ☐ YES ☐ NO

OCCUPATION _____

HOBBIES _____

COMMENTS

_____

_____

_____

Patient Name (Print) _____ Patient Signature _____