Cherokee Eye Clinic Medical History Questionnaire

(Please CIRCLE your answers)

Name: Today’s Date:

Address: Phone:

 City: Zip: Cell Phone:

Guardian (if applicable): Work Phone:

Date of Birth: / / Social Security #: / / Occupation:

Name of Medical Doctor: OK to text? YES NO (circle one)

Email Address: Hobbies:

Are you currently enrolled in **HOSPICE**? YES NO What **PHARMACY** do you use?

Do you have any allergies to medications? YES NO If yes, explain:

Are you current with flu shots & pneumonia vaccine?

List any medications you take with STRENGTH & DOSAGE (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had:

List any of the following that you have had: Crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury:

Are you pregnant and/or nursing? YES NO

Do you wear glasses? YES NO If yes, how old is your present pair of lenses?

Do you wear contact lenses? YES NO If yes, how old is your present pair of lenses?

Type of contact lenses: RIGID SOFT EXTENDED WEAR OTHER Are they comfortable? YES NO

**Family History** \*Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Disease/Condition | YES | NO | ? | Relationship to you |
| Blindness |  |  |  |  |
| Cataract |  |  |  |  |
| Crossed Eyes |  |  |  |  |
| Glaucoma |  |  |  |  |
| Macular Degeneration |  |  |  |  |
| Retinal Detachment/Disease |  |  |  |  |
| Arthritis |  |  |  |  |
| Cancer |  |  |  |  |
| Diabetes |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Lupus |  |  |  |  |
| Thyroid Disease |  |  |  |  |
| Other: |  |  |  |  |

*\*\*Please turn this form over and complete side two\*\**

**Social History** \*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? YES NO If yes, do you have visual difficulty when driving? YES NO

If yes, please describe:

Do you use tobacco products? YES NO

\*Tobacco use is the leading cause of preventable death & disease in the U.S. Would you like cessation program information? YES NO

Do you drink alcohol? YES NO If yes, type/amount/how long:

Do you use illegal drugs? YES NO If yes, type/amount/how long:

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| System | Yes | NO | ? | SYSTEM | Yes | No | ? |
| **CONSTITUTIONAL** |  |  |  | **EARS, NOSE, MOUTH, THROAT** |  |  |  |
|  Fever, Wight loss/gain |  |  |  |  Allergies/Hay Fever |  |  |  |
| **INTEGUMENTARY (skin)** |  |  |  |  Sinus Congestion |  |  |  |
| **NEUROLOGICAL** |  |  |  |  Runny Nose |  |  |  |
|  Headaches |  |  |  |  Pose-Nasal Drip |  |  |  |
|  Migraines |  |  |  |  Chronic Cough |  |  |  |
|  Seizures |  |  |  |  Dry Throat/Mouth |  |  |  |
| **EYES** |  |  |  | **RESPIRATORY** |  |  |  |
|  Loss of Vision |  |  |  |  Asthma |  |  |  |
|  Blurred Vision |  |  |  |  Chronic Bronchitis |  |  |  |
|  Distorted Vision/Halos |  |  |  |  Emphysema |  |  |  |
|  Loss of Side Vision |  |  |  | **VASCULAR / CARDIOVASCULAR** |  |  |  |
|  Double Vision |  |  |  |  Diabetes |  |  |  |
|  Dryness |  |  |  |  Heart Pain |  |  |  |
|  Mucous Discharge |  |  |  |  High Blood Pressure |  |  |  |
|  Redness |  |  |  |  Vascular Disease |  |  |  |
|  Sandy or Gritty Feeling |  |  |  | **GASTROINTESTINAL** |  |  |  |
|  Itching |  |  |  |  Diarrhea |  |  |  |
|  Burning |  |  |  |  Constipation |  |  |  |
|  Foreign Body Sensation |  |  |  | **GENTIOURINARY** |  |  |  |
|  Excess Tearing/Watering |  |  |  |  Genitals/ Kidney/ Bladder |  |  |  |
|  Glare/Light Sensitivity |  |  |  | **BONES/JOINTS/MUSCLES** |  |  |  |
|  Eye Pain or Soreness |  |  |  |  Rheumatoid Arthritis |  |  |  |
|  Chronic Infection of Eye or Lid |  |  |  |  Muscle Pain |  |  |  |
|  Sties or Chalazion |  |  |  |  Joint Pain |  |  |  |
|  Flashes/ Floaters in Vision |  |  |  | **LYMPHATIC/HEMATOLOGIC** |  |  |  |
|  Tired Eyes |  |  |  |  Anemia |  |  |  |
| **ENDOCRINE** |  |  |  |  Bleeding Problems |  |  |  |
|  Thyroid/Other Glands |  |  |  | **ALLERGIC/IMMUNOLOGIC** |  |  |  |
| **HEARING DIFFICUTIES** |  |  |  | **PSYCHIATRIC** |  |  |  |

If you answered **YES** to any of the above or have a condition not listed, please explain & list medications:

Doctor’s Signature: Date: