NEVADA EYE PHYSICIANS

Medical History Questionnaire

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **PCP**: _____ **Referring Physician**: _____

Vaccinations

Have you had the following:

Influenza Vaccine	_____ Yes	_____ No	If yes, when: _____
Pneumococcal Vaccine	_____ Yes	_____ No	If yes, when: _____

Allergies

Name: _____ Reaction: _____

Name: _____ Reaction: _____

Current Medications

Name	Dosage	Frequency

Past Medical History

☐AIDS/HIV	☐Diabetes	☐Macular Degeneration	☐Arthritis	☐Glaucoma
☐Retinal Disorder	☐Blindness	☐Heart Disease	☐Sjogren's Syndrome	☐Cancer
☐High Cholesterol	☐Strabismus (Lazy Eye)	☐Cataracts	☐Kidney Disorder	☐Stroke
☐Corneal Disease	☐High Blood Pressure	☐Lupus	☐Heart Attack	☐Thyroid Disease

Hospitalization & Surgeries

Reason	Date

Social History

Do you smoke?	_____ Current	_____ Former	_____ Never
If yes: Occasional	$^1/_2$ pack per day	1+ pack per day	
Do you drink alcohol?	_____ Current	_____ Former	_____ Never
If yes: Occasional	1 per day	2-3 per day	4+ per day
Drug use?	_____ Yes	_____ No	_____ Formerly
Caffeine?	_____ Yes	_____ No	Amount per day _____

When filling out paperwork in advance, please bring with you to your scheduled exam

Do you have any of the following? Please circle all that apply.

Constitutional
☐ All Negative
Fatigue
Fever
Night sweats
Weakness
Weight Gain

HEENT
☐ All Negative
Exophthalmos (Bulging Eyeball)
Hearing Loss
Hoarseness
Lump in neck
Nasal congestion
Sinus Problems
Sore Throat
Tinnitus (Ringing in ears)
Vertigo

Respiratory
☐ All Negative
Asthma
Cough
Dyspnea (Breathing Difficulty)
Hemoptysis (Coughing up blood)
Wheezing

Cardiovascular
☐ All Negative
Arrhythmia (Irregular heartbeat)
Calf Pain
Chest Pressure / Discomfort
Heart Palpitations
Leg Swelling
Tachycardia (Fast heartbeat)

Gastrointestinal
☐ All Negative
Abdominal Pain
Black Stool
Constipation
Decreased Appetite
Diarrhea
Dysphagia (Difficult swallowing)
Food Intolerance
Heartburn
Increased Appetite
Jaundice
Nausea
Vomiting

Genitourinary
☐ All Negative
Painful Urination
Genital Lesions
Hematuria (Blood in Urine)
Irregular Menses
Urethral Discharge

Endocrine
☐ All Negative
Cold Intolerance
Heat Intolerance
Polydipsia (Excessive Thirst)
Polyphagia (Increased Appetite)
Polyuria (Frequent Urination)

Neurological
☐ All Negative
Balance Disturbances
Dizziness
Focal Weakness
Gait Disturbance
Headache
Memory Difficulty
Numbness of Extremities
Psychiatric

Psychiatric
☐ All Negative
Depressed Mood
Emotional Changes
Euphoria
Frequent Nightmares
Hallucinations
Insomnia
Irritability
Nervousness
Stress

Integumentary
☐ All Negative
Abnormal Hair Distribution
Dry Skin
Hives
Itching Skin
Nail Changes
Rash
Skin changes
Skin lesion
Skin Ulcer

Musculoskeletal
☐ All Negative
Arthralgias (Joint Pain)
Back Pain
Fracture
Joint Stiffness
Joint Swelling
Muscle Cramping
Muscle Weakness

Hematologic/Lymphatic
☐ All Negative
Bleeding
Bruising
Tender Lymph Nodes
Lymphadenopathy (Enlarged Lymph Nodes)

Immunologic
☐ All Negative
Environmental Allergies
Food Allergies
Seasonal Allergies

Family History

☐ Adopted, no family history known

M = Mother, F = Father, B = Brother, S = Sister, GP = Grandparent

DISEASE	YES	NO	
Amblyopia			
Cataracts			
Macular Degeneration			
Retinal Disorders			
Strabismus			
High Blood Pressure			
Diabetes			
Heart Disease			
Arthritis			
Asthma			
Cancer			
Respiratory Disease			
Circulatory Disorders			

Blood Sugar Control Glucose_____ Date last checked_____HbA1C_____Date last checked_____