Retina Specialists of Alabama in Montgomery

MEDICAL AND OCULAR

HISTORY QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Height: _____ (inches) Weight: _____ (pounds)

Eye Doctor: _____ Address: _____
(First) (Last)

Medical Doctor: _____ Address: _____
(First) (Last)

Other: _____ Address: _____
(First) (Last)

Please answer the following questions to the best of your ability. Give dates, a brief description, and which eye was involved to any yes question.

MEDICAL / SURGICAL HISTORY

Have you had any serious medical problems? ❑ No ❑ Yes

(for example: heart, lung, kidney disease, high blood pressure or cancer)

If yes, please describe. _____

Do you have diabetes? ❑ No ❑ Yes

❑ Type I ❑ Type II

How long have you had diabetes? _____

How often do you test your blood sugar? _____ Hemoglobin A1C? _____

How high was your blood sugar when last tested? _____

Have you ever been exposed to HIV or AIDS ❑ No ❑ Yes

Are you HIV Positive? ❑ No ❑ Yes

If yes, CD4 count: _____ Date: _____

Have you ever been hospitalized for any reason? ❑ No ❑ Yes

If yes, please describe: _____

Have you had any major surgery? ❑ No ❑ Yes

If yes, please describe: _____

Have you had any complications from anesthesia? ❑ No ❑ Yes

If yes, please describe: _____

Patient Name: _____ Date: _____

Does your vision make it difficult for you to function in activities of daily living? ❑ No ❑ Yes

Please describe: _____

SMOKING STATUS (circle One)

Current smoker	Current every day smoker	Chewing Nicotine product
Former smoker	Current some day smoker	Previous history of using chewing tobacco
Never smoked	Attempting to quit using chewing tobacco	Using nasal snuff
	Recently quit using chewing tobacco	

FAMILY HISTORY

Is there any eye disease which runs in your family? ❑ No ❑ Yes

(for example: glaucoma, retinal detachment, or retinal degeneration)

If yes, please describe: _____

Has any member of your family lost vision for any reason? ❑ No ❑ Yes

If yes, please describe: _____

Is there any significant medical disease which runs in your family? ❑ No ❑ Yes

(for example: heart, lung, or kidney disease, high blood pressure or cancer)

If yes, please describe: _____

Are you taking vitamins for your eyes? ❑ No ❑ Yes

Please list **any** medication(s) including **eye drops**, which you are taking.

Name of Medication	Amount Taken	Times Taken	Eye

Please list any medication allergies:

Name of Medication	Reaction	Date of First Occurrence

Patient Name: _____ DATE: _____

REVIEW OF SYSTEMS - Do you CURRENTLY have:

CARDIOVASCULAR:

CHEST PAIN?	❑ NO	❑ YES
ENLARGED HEART?	❑ NO	❑ YES
HEART DISEASE	❑ NO	❑ YES
HEART MURMUR	❑ NO	❑ YES
IRREGULAR HEART BEAT	❑ NO	❑ YES
SHORTNESS OF BREATH	❑ NO	❑ YES
SWELLING OF FEET	❑ NO	❑ YES
BLOOD CLOTS	❑ NO	❑ YES
HIGH BLOOD PRESSURE	❑ NO	❑ YES
HIGH CHOLESTEROL	❑ NO	❑ YES
PACE MAKER	❑ NO	❑ YES
DEFIBRILLATOR	❑ NO	❑ YES
HEART STENTS	❑ NO	❑ YES
BYPASS SURGERY	❑ NO	❑ YES

HEMATOLOGY:

ANEMIA	❑ NO	❑ YES
BLEEDING DISEASE	❑ NO	❑ YES
SICKLE CELL DISEASE	❑ NO	❑ YES

NEUROLOGY:

STROKE	❑ NO	❑ YES
SEIZURES	❑ NO	❑ YES
PARALYSIS	❑ NO	❑ YES
DIZZINESS	❑ NO	❑ YES
DOUBLE VISION	❑ NO	❑ YES
MULTIPLE SCLEROSIS	❑ NO	❑ YES
HAD A BRAIN SCAN?	❑ NO	❑ YES
WHAT YEAR? _____		

GENITOURINARY:

KIDNEY TROUBLE	❑ NO	❑ YES
URINE PROBLEM	❑ NO	❑ YES
GONORRHEA	❑ NO	❑ YES
SYPHILIS	❑ NO	❑ YES
OTHER?_____	❑ NO	❑ YES
HIV?	❑ NO	❑ YES

PULMONARY:

ASTHMA	❑ No	❑ Yes
EMPHYSEMA	❑ No	❑ Yes
COUGH	❑ No	❑ Yes
LUNG DISEASE	❑ No	❑ Yes
PNEUMONIA	❑ No	❑ Yes
T.B.	❑ No	❑ Yes
WHEEZING	❑ No	❑ Yes
BRONCHITIS	❑ No	❑ Yes

ENDOCRINE:

THYROID DISEASE	❑ No	❑ Yes
DIABETES	❑ No	❑ Yes
DIABETIC NEUROPATHY	❑ No	❑ Yes
DIABETIC FOOT ULCERS	❑ No	❑ Yes
DIABETIC KIDNEY FAILURE	❑ No	❑ Yes

PSYCHIATRY:

DEPRESSION	❑ No	❑ Yes
OTHER DISORDERS	❑ No	❑ Yes

GASTROENTEROLOGY:

STOMACH TROUBLE	❑ No	❑ Yes
TROUBLE WITH INTESTINES	❑ No	❑ Yes
HEPATITIS	❑ No	❑ Yes
PORPHYRIA	❑ No	❑ Yes

REPRODUCTIVE:

ARE YOU PREGNANT	❑ No	❑ Yes
DATE OF LAST MENSTRUAL PERIOD? _____		

RHEUMATOLOGY:

TROUBLE WITH YOUR JOINTS	❑ No	❑ Yes
BACK TROUBLE	❑ No	❑ Yes
LYME DISEASE	❑ No	❑ Yes
SARCOIDOSIS	❑ No	❑ Yes
OTHER INFLAMMATORY DISORDERS	❑ No	❑ Yes
DESCRIBE: _____		

PLEASE DESCRIBE YOUR CURRENT EYE PROBLEM.

OCULAR HISTORY

Have you ever had any eye disease, surgery or injury in the past? ❑ No ❑ Yes

If yes, please describe. Include dates and the name of the doctor who treated you.

Doctor	Date	Describe	Which Eye

Did any previous eye disorder result in loss of vision? ❑ No ❑ Yes

If yes, please describe.

Have you ever been told you have amblyopia or "lazy eye"? ❑ No ❑ Yes

THIS SPACE RESERVED FOR PHYSICIAN ONLY

Chief Complaint:

Reason for Consultation:

History of Present Illness: (Location, Quality, Severity, Duration, Context, Modifying Factors, Timing)

Orientation to time, place and person: ❑ Normal ❑ Other:

Mood/affect: ❑ Normal ❑ Other:

Physician's Signature: Tech Signature: Date:

Physician's Signature: Tech Signature: Date:

Physician's Signature: Tech Signature: Date: