LUDWICK EYE CENTER
MEDICAL HISTORY QUESTIONNAIRE

NAME:____DATE:____

DATE OF BIRTH:_____________DATE LAST EYE EXAM:___________BY WHOM?_______________________________________

List any **medications including eye drops** you currently take (prescription and over-the-counter):____________________
____
____
____
____
____

Do you have **allergies** to any <u>medications</u>? YES NO

If YES, list the medications:____

Do you have **allergies** to any <u>food</u>? YES NO
If YES, list the food:____

LIST ALL MAJOR SYSTEMIC ILLNESSES	YES	NO	UNKNOWN	DETAILS
Lung Disease				
Seasonal Allergies				
Kidney Stones				
Kidney Disease				
Diabetes				
How long have you had Diabetes				
How do you control your Diabetes				
Do you check your blood sugar				
Result of your last blood sugar				
Last Hemoglobin A1c				
High Blood Pressure				
Result of last Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Headaches				
Gout				
Skin Disease				
Gastrointestinal Disease				
Blood Disorders				
Multiple Sclerosis				
Other Major Illness or Hospitalization				

LIST EYE DISEASES	YES	NO	DETAILS
Eye Trauma			
Cataracts			
Macular Degeneration			
Retinal Detachment/Retinal Holes			
Diabetic Retinopathy			
Corneal Dystrophy			
Lattice Degeneration			
Dry Eye Syndrome			
Glaucoma			
Eye Surgery and When			
Surgeon for Eye Surgery			
Infection (corneal ulcer)			
Uveitis / Iritis			
Crossed-Eyes / Lazy Eye			
Color Blindness			
Laser surgery and When			
Surgeon for Laser Eye Surgery			
Other Eye Diseases			

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	YES	NO	DETAILS
EYES (blurred vision, glare, redness, pain, tearing, burning, itching, etc.)			
GENERAL/CONSTITUTIONAL (fever, weight loss, weight gain, fatigue, cancer)			
EARS (ear ache)			
NOSE (stuffy nose)			
THROAT (dry mouth)			
CARDIOVASCULAR (high BP, congestive heart failure, chest pain, heart attack, carotid disease, irregular heartbeat, etc.)			
RESPIRATORY (wheezing, asthma, emphysema, coughing, bronchitis, TB, shortness of breath, etc.)			
GASTROINTESTIONAL (stomach ulcers, intestinal disease, ulcerative colitis, Crohn's, diarrhea, etc.)			
FEMALES: Are you Pregnant? Nursing?			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, kidney stones, kidney failure, etc.)			
MUSCLES, BONES, JOINTS (Musculoskeletal) (joint pain, stiffness, swelling, osteoarthritis, rheumatoid arthritis, fibromyalgia, gout, etc.)			
SKIN (pimples, warts, growths, rash, eczema, seborrhea, psoriasis, etc.)			
NEUROLOGICAL (numbness, headache, stroke, seizures, multiple sclerosis, myasthenia gravis, migraines, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, claustrophobia, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
BLOOD / LYMPH (bleeding problems, anemia, sickle cell, high cholesterol, thalassemia, HIV/AIDS, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, seasonal allergies, etc.)			

Has any member of your family had these diseases? *(Mother, Father, Grandparent, Sibling)*

FAMILY HISTORY	YES	NO	UNKNOWN	DETAILS
Blindness				
Cataract				
Glaucoma				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Macular Degeneration				
Color Blindness				
Strabismus (crossed eye)				
Multiple Sclerosis				
Other (Explain)				
Family History Unknown				

SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed

Type of Employment:____

Do you live alone? Yes No

If YES, is there someone who can help you?

Name:____________________________Phone:____________________

Have you ever had a blood transfusion? Yes No

PHARMACY/Address:____

Do you drink alcohol? Yes No If Yes: occasional 1/day 2-3/day 4+/day

Do you smoke? Yes NO If Yes: occasional ½ pack/day 1 pack/day 1+pack/day

How many years?____________________ When did you quit?____________________

FAMILY DOCTOR:____

REFERRING EYE DOCTOR:____

HOW WERE YOU REFERRED? Optometrist Family Doctor Yellow Pages Friend Newspaper

Other (Explain)____

Signature:________________________________ Date:________________

Reviewed by Doctor:________________________________ Date:________________