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) ______________

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Do you have **allergies** to any medications? YES NO

If YES, list the medications: ______________________________

List all major systemic illnesses:

	YES	NO	UNKNOWN	DETAILS
Lung Disease				
Seasonal Allergies				
Kidney Stones				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Headaches				
Gout				
Skin Disease				
Gastrointestinal Disease				
Blood Disorders				
Multiple Sclerosis				
Other (Explain)				

List eye diseases:

	YES	NO	DETAILS
Eye injury			
Cataracts			
Macular Degeneration			
Retinal Detachment/Retinal Holes			
Diabetic Retinopathy			
Corneal Dystrophy			
Lattice Degeneration			
Dry Eye Syndrome			
Glaucoma			
Infection(corneal ulcer)			
Uveitis/Iritis			
Crossed-Eyes/Lazy Eye			
Color Blindness			
Other (EXPLAIN)			

List eye surgeries (cataract, glaucoma, LASIK, retinal, laser, lids etc.):____

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List any other surgeries you have had (appendectomy, heart surgery, etc.): ______________________________________

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Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (blurred vision, glare, redness, pain, tearing, burning, itching, etc.)			
GENERAL/CONSTITUTIONAL (fever, weight loss, weight gain, fatigue, cancer)			
EARS, NOSE, THROAT (stuffy nose, ear ache, dry mouth, etc.)			
CARDIOVASCULAR (high BP, congestive heart failure, chest pain, heart attack, carotid disease, irregular heart beat, etc.)			
RESPIRATORY (wheezing, asthma, emphysema, coughing, bronchitis, TB, shortness of breath, etc.)			
GASTROINTESTINAL (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 (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.)			

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

	YES	NO	UNKNOWN	DETAILS
Blindness				
Cataract				
Glaucoma				
Diabetes				
Hypertension				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Macular Degeneration				
Color Blindness				
Strabismus (crossed eyes)				
Multiple Sclerosis				
Other (Explain)				

SOCIAL HISTORY:
Marital Status: Single Married Divorced Widowed

Type of Employment: ____

Do you live alone? Yes or No
If YES, is there someone who can help you? Name:______________________________________ Phone:______________

Have you ever had a blood transfusion? YES NO

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: _______________