Medical History Questionnaire

LUDWICK EYE CENTER

Name: _____ **Date Of Birth:** _____

Date: _____ **Referring Eye Doctor:** _____

Do you have allergies to any medications or food? YES NO

If yes, please list the medications: _____

Past History of Ocular Health Status:

OCULAR HISTORY	YES	NO	DETAILS
Eye Trauma			
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			

Please list any **eye surgery** you have had: _____

_____

Please list any **eye drops** you currently take *(prescription and over-the-counter)*: _____

_____

Social History *(please circle)*:

Do you drink alcohol?	No	Yes, occasional	Yes, socially	Yes, 1 per day	Yes, 2-3 per day
Do you smoke?	No	Former smoker	Yes, some days	Yes, every day	
Do you use illegal drugs?	No	Yes	Drugs Used: _____		

Please see back

Past History of Medical Health Status:

MEDICAL HISTORY	YES	NO	UNKNOWN	DETAILS
Lung Disease				
Seasonal Allergies				
Kidney Stones				
Kidney Disease				
Diabetes				*How long? Last blood sugar reading? Last A1c?*
High Blood Pressure				
Heart Disease				
Stroke				
Cancer				
Thyroid Disease				
Arthritis				
Headaches				
Gout				
Skin Disease				
Gastrointestinal Disease				
Blood Disorders				
Multiple Sclerosis				

Other Major Illness/Hospitalizations/Surgeries: _____

_____

_____

_____

Medications *(not including eye drops)*: _____

_____

_____

_____

_____

_____

Current Ocular & Medical Health Status *(please circle)*

EYES			RESPIRATORY			BLOOD/LYMPHNODES		
Previous Surgery	Yes	No	Cough	Yes	No	Easy Bruising	Yes	No
Contact Lens	Yes	No	Congestion	Yes	No	Gums Bleed Easily	Yes	No
Pain	Yes	No	Wheezing	Yes	No	Prolonged Bleeding	Yes	No
Double Vision	Yes	No	Asthma	Yes	No	Heavy Aspirin Use	Yes	No
Glaucoma	Yes	No	**GASTROINTESTINAL**			Diabetes	Yes	No
Cataracts	Yes	No	Heartburn	Yes	No	**MUSCULOSKELETAL**		
Macular Degeneration	Yes	No	Nausea/Vomiting	Yes	No	Stiffness	Yes	No
Dry Eyes	Yes	No	Jaundice/Hepatitis	Yes	No	Arthritis	Yes	No
Flashes/Floaters	Yes	No	Acid Reflux	Yes	No	Joint Pain/Swelling	Yes	No
Blurred Vision	Yes	No	**GENITO-URINARY**			**SKIN**		
EAR, NOSE & THROAT			Pain/Difficulty	Yes	No	Rash/Sores	Yes	No
Hard of Hearing	Yes	No	Blood in Urine	Yes	No	Lesions	Yes	No
Ringing in Ears	Yes	No	History of Kidney Stones	Yes	No	Hives/Eczema	Yes	No
Vertigo	Yes	No	History of STDS	Yes	No	**NEUROLOGICAL**		
CARDIOVASCULAR			**PSYCHIATRIC**			Seizures	Yes	No
Chest Pain	Yes	No	Anxiety/Depression	Yes	No	Weakness/Paralysis	Yes	No
Dizziness	Yes	No	Mood Swings	Yes	No	Numbness	Yes	No
Fainting Spells	Yes	No	Difficulty Sleeping	Yes	No	Tremors	Yes	No
Shortness of Breath	Yes	No	**ENDOCRINE**			**IMMUNOLOGIC**		
Irregular Heart Beat	Yes	No	Increased Thirst	Yes	No	Hives	Yes	No
Difficulty Lying Flat	Yes	No	Increased Hunger	Yes	No	Itching	Yes	No
Hypertension	Yes	No	Increased Urination	Yes	No	Runny Nose	Yes	No
High Cholesterol	Yes	No	Increased Sweating	Yes	No	Sinus Pressure	Yes	No
CONSTITUTIONAL			Fingernail Changes	Yes	No			
Fatigue/Weakness	Yes	No						
Fever	Yes	No						
Weight Gain/Loss	Yes	No						

Has any member of your family had any of the following diseases? *(Mother, father, grandparent, sibling)*

☐ Diabetes ☐ Stroke ☐ Blindness ☐ Macular Degeneration ☐ Arthritis
☐ Cancer ☐ TB ☐ Cataract ☐ Retinal Disease ☐ Lazy Eye
☐ Heart Disease ☐ Kidney Disease ☐ Glaucoma ☐ High Blood Pressure

☐ Other:_____

☐ Family History Unknown- Reason: _____

Signature: _____ **Date:** _____

Thank you for providing us with the information above, it will allow us to better care for you. We hope you enjoy your time with us today.