EYE CARE & SURGEONS OF CHARLOTTE, PLLC

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Nickname**: _____ **Date of Birth**: ___/____/_____

Primary Care Physician: _____**Referring /Specialty Dr**._____

Pharmacy:_____ **Location**(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese
□ Russian □ Spanish □ Portuguese

Allergies: Reaction Severity

_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted)
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Trabeculectomy
□ Blepharoplasty □ Retinal Laser Surgery □ RK □ (Glaucoma surgery)
□ Cataract Surgery □ LASIK □ Strabismus Surgery (eye muscle) □ Vitrectomy
□ Corneal Transplant □ PRK
Other_____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses:

□ No history of illnesses □ Congestive Heart Failure □ Hepatitis □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes □ High Cholesterol □ Migraine
□ Arrhythmia □ Eczema □ HIV □ Polymyalgia
□ Asthma □ Fibromyalgia □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Headache □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Thyroid Disease
Other_____

BACK →

EYE CARE & SURGEONS OF CHARLOTTE. PLLC

General Surgeries / Operations: (Please list)

_____

_____

Current Other Medications: (Please list)

_____

_____

_____

Family History:

□ Arthritis □ Diabetes □ Kidney Disease □ Stroke
□ Blindness □ Glaucoma □ Lazy Eye □ TB
□ Cancer □ Heart Disease □ Macular Degeneration
□ Cataracts □ High Blood Pressure □ Retinal Disease
Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked
Alcohol Use: □ Yes □ No If yes how much and how often? _____
Drug Use: □ Yes □ No If yes what and how often? _____

Review of Systems: (Please mark all that apply)

Eyes
□ Previous Surgery
□ Contact Lens
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters

Ear, Nose, and Throat
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo

Cardiovascular
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heartbeat
□ Difficulty Lying Flat

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitis

Genito-Urinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Mood Swings
□ Difficulty Sleeping

Blood / Lymph Nodes
□ Easy Bruising
□ Gums Bleed Easy
□ Prolonged Bleeding
□ Heavy Aspirin Use

Musculoskeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Hives / Eczema

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness
□ Tremors

Signature _____ Date _____