Medical History Questionnaire

North Dakota Eye Clinic

Name: _____ Sex: M F
(LAST) (FIRST) (MIDDLE)

Date of Birth: _____ Age: _____ Occupation: _____
mm/dd/yyyy

Primary Medical Physician: _____ Clinic/Location: _____

Pharmacy: _____

Were you referred by an Optometrist? No ☐ Yes ☐ Provider name:

Eye Health History

Have YOU ever been diagnosed with any of the following?

Check all that apply

- ☐ Amblyopia (lazy eye)
- ☐ Aphakia
- ☐ Astigmatism
- ☐ Cataracts
- ☐ Diabetic Retinopthy
- ☐ Dry eye
- ☐ Glaucoma
- ☐ Hyperopia (farsighted)
- ☐ Iritis
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Myopia (nearsighted)
- ☐ Optic Neuritis
- ☐ Presbyopia
- ☐ Retinal Conditions
- ☐ Retinal Detachment
- ☐ Sjogrens Syndrome
- ☐ None of the above
- ☐ Trauma/Injury (please explain): _____
- ☐ Other (please explain): _____

Eye Surgeries/Procedures

Have YOU ever had any of the following surgeries?

Check all that apply

- ☐ Blepharoplasty
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ Enucleation
- ☐ Foreign Body Removal
- ☐ LASIK
- ☐ Natural Lens Replacement
- ☐ PRK
- ☐ Punctal Dilation/Plugs
- ☐ Retinal Procedures
- ☐ RK
- ☐ Strabismus/Muscle Surgery
- ☐ Trabeculectomy
- ☐ Vitrectomy
- ☐ None of the above
- ☐ Other (please explain): _____

General Health History

Have/Are YOU being treated for any of the following?

Check all that apply

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Graves Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Stroke (CVA)
- ☐ Thyroid Disease
- ☐ None of the above
- ☐ Other (please explain): _____

Continued on reverse side ➞

General Medical Surgeries/Procedures

Have YOU ever had any of the following surgeries?

*** Check all that apply****

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Carpal Tunnel
- ☐ C-Section
- ☐ Foot Surgery
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Heart Stents
- ☐ Hernia Surgery
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Neck Surgery
- ☐ Oral/Dental Surgery
- ☐ Pacemaker
- ☐ Shoulder Surgery
- ☐ Skin Cancer
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Wrist Surgery
- ☐ None of the above
- ☐ Other (please explain): _____

Medication

Please list all medications you are currently taking:

☐ I am currently NOT on any medication

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

Please list your medication allergies and reaction:

☐ I have NO allergies

Allergen:	*Reaction:*
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Immediate relatives:

	Relative		*Relative*
☐ Auto-Immune	_____	☐ Heart Disease	_____
☐ Blindness	_____	☐ Hypertension	_____
☐ Cancer	_____	☐ Macular Degeneration	_____
☐ Diabetes	_____	☐ Stroke	_____
☐ Glaucoma	_____	☐ Other	_____

Social History

Please tell us about your social history:

☐ Tobacco *(amount):* _____ ☐ Alcohol *(amount):* _____

I acknowledge that I have read and completed this form to the best of my ability and that the above information is accurate to the best of my knowledge.

_____ _____ _____

Signature *Relation (if not self)* *Date*