HOLLAND EYE SURGERY & LASER CENTER

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## MEDICAL HISTORY QUESTIONAIRE

Name:____________________________________________ Today's date:__________________

Date of birth:______________ Circle: Male Female **Family Doctor**:___________________

| **Past Ocular History:** | **Y** | **N** | **Explanation** |
|---|---|---|---|
| Eye Injuries | | | |
| Cataracts | | | |
| Glaucoma | | | |
| Crossed/lazy eyes | | | |
| Eye Surgeries | | | |
| Other | | | |

| **Current Medical Conditions:** | **Y** | **N** | **Explanation** |
|---|---|---|---|
| Diabetes | | | ☐ Type I ☐ Type II Year diagnosed_______ A1C level________ Date Done___________ |
| Gastrointestinal | | | |
| Thyroid disorders | | | |
| Heart disease | | | |
| Headaches/dizziness | | | |
| Genital/kidney/urinary disorders | | | |
| Skin disorders | | | |
| Allergic/Immunologic disorders | | | |
| Are you pregnant or nursing? | | | |
| Cancer | | | |
| High blood pressure | | | |
| Stroke | | | |
| Respiratory | | | |
| Muscle/Bone/Joint disorders | | | |
| Ear/nose/throat problems | | | |
| Neurological disorders | | | |
| Psychological disorders | | | |
| Blood/Bleeding disorders | | | |
| High cholesterol | | | |
| Other | | | |

**SEE NEXT PAGE**

PATIENT NAME:_________________________________DATE OF BIRTH____________________________

**Current Medications: name and strength (mg), including over the counter medications**

Example: Lisinopril 20 mg, Aspirin 81 mg

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**Eye Medications:**

_____________________________ _____________________________ _____________________________

**Allergies: medication name and <u>REACTION</u>**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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**Surgical History: list all surgeries and dates**

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| Family Ocular History: | Y | N | Relation | Family Medical History | Y | N | Relation |
|---|---|---|---|---|---|---|---|
| Retinal Detachment | | | | Diabetes | | | |
| Macular Degeneration | | | | Hypertension | | | |
| Diabetic Retinopathy | | | | Heart Disease | | | |
| Cataracts | | | | Other: | | | |
| Glaucoma | | | | | | | |

**Social History:**

Do you smoke? ☐ Yes ☐ No If yes, how much?______ How many years?______

If you quit smoking, when?___________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?______________________________

Have you fallen within the last year? ☐ Yes ☐ No

Pharmacy: ________________________________________________________________________

Address: ______________________________________ City: _____________________________________

| FOR OFFICE USE ONLY: | |
|---|---|
| Reviewed by: | |
| ______________________________ Doctor's Signature | ______________________________ Date |