Long Beach Eye Care
ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name _____ Family Physician _____

PAST HISTORY Please provide a list of the following:

Current Medications _____
Current Eye Medications _____
Allergies to Medications _____
All Previous Surgeries _____

FAMILY HISTORY Please indicate if any direct blood relatives have the following problems.

If possible, tell us if it was your (F)ather, (M)other, (B)rother, (S)ister, (GF)Grandfather or (GM)Grandmother.

Glaucoma _____ Retinal Problems _____ Diabetes _____ Cataract _____ High Blood Pressure _____
Cancer_____ Heart Disease _____ Arthritis _____ Blindness _____ Stroke _____ Other _____

REVIEW OF SYSTEMS Please list any current problems in the following areas:

AREAS	YES	NO	DESCRIPTION
Dermatologic (Skin, Hair, Nails)	❑ Yes	❑ No	
Ears, Nose, Throat, Mouth,	❑ Yes	❑ No	
Sinus, Dry Mouth/Throat, Neck	❑ Yes	❑ No	
Respiratory (lungs/breathing)	❑ Yes	❑ No	
Cardiovascular (heart/blood pressure)	❑ Yes	❑ No	
Gastrointestinal(stomach/intestines)	❑ Yes	❑ No	
Genitourinary (kidney/genitals/bladder)	❑ Yes	❑ No	
Musculoskeletal (Bones/Joints/Muscles)	❑ Yes	❑ No	
Neurologic (numbness, migraines)	❑ Yes	❑ No	
Lymphatic (lymph node swelling)	❑ Yes	❑ No	
Hematologic (bleeding, bruising, clots)	❑ Yes	❑ No	
Endocrine (thyroid, pituitary, diabetes)	❑ Yes	❑ No	

If **Diabetic**: Year Diagnosed _____ Last Blood Sugar _____ Date of Last Blood Sugar _____
Controlled by: Diet _____ Exercise _____ Medication _____ Insulin _____ How many Units _____
Are you Pregnant? ❑ Yes ❑ No

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No How many packs per week? _____
Do you drink? ❑ Yes ❑ No How many drinks per week? _____
Recreational drugs? ❑ Yes ❑ No Types and frequency _____

OPHTHALMIC HISTORY

List any eye surgeries, left or right side, and year if possible: _____
When was your last glasses/contact lens prescription? (Or enter "none") _____
If you use contact lenses, what brand are they? _____
Please list any eye injuries (side, mechanism, date): _____
Do you have problems with: ❑ Floaters ❑ Tearing ❑ Double Vision ❑ Itching Burning ❑ Eye Pain
❑ Allergies ❑ Trouble seeing the computer ❑ Near vision problems ❑ Eye Strain
❑ Headache ❑ Glare ❑ Difficulty with Night Driving or Headlights

What is the reason for this exam? _____