HUGHES EYE GROUP MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ **Preferred/Nickname**: ________________ **Date of Birth**: ____________

Primary Physician: ___________________ **Referring Physician:**____

Primary Eye Doctor: ____

Pharmacy:__________________________ **Pharmacy Location** (City/Street):___________________________________

Race: □ African American □ American Indian or Alaska Native □ Asian □ Caucasian □ Native Hawaiian/Other Pacific Islander

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ Spanish □ Other: _______________________________________

Allergies to Medications: (List medication, type of reaction, and severity of reaction)

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Ocular History: (Mark all that apply)

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

Ocular Surgeries: (Mark all that apply)

□ No ocular surgery □ Foreign Body Removal □ Retinal Laser Surgery □ Vitrectomy
□ Blepharoplasty □ LASIK □ RK □ Yag Capsulotomy (After Cataract Laser)
□ Cataract Surgery □ PRK □ Strabismus/ Muscle Surgery
□ Corneal Transplant □ Punctal Plugs □ Trabeculectomy (Glaucoma Surgery)
Other____

Current Ocular Medications: (Eye Drops, Eye Ointments, Ocular Vitamins, etc)

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Medical History:

□ Overall Healthy
□ AIDS □ Crohn's Disease □ Hearing Loss □ Migraine
□ Anemia □ Congestive Heart Failure □ Heart Attack □ Multiple Sclerosis
□ Aneurysm □ COPD □ High Blood Pressure □ Polymyalgia
□ Ankylosing Spondylitis □ Diabetes (Type 1 or 2) □ High Cholesterol □ Psychiatric Disorder
□ Arthritis □ Dementia □ HIV □ Rheumatoid Arthritis
□ Arrhythmia □ Eczema □ Kidney Disease □ Sjogren's Syndrome
□ Asthma □ Fibromyalgia □ Kidney Stones □ Stroke
□ Bleeding Disorder □ Graves' Disease □ Lung Disease □ Thyroid Disease
□ Cancer □ Headache □ Liver Disease □ Ulcerative Colitis
Other:____

Infection History:

□ Overall Healthy □ Herpes Simplex □ HIV / AIDS □ Syphilis
□ Chicken Pox □ Herpes Zoster / Shingles □ Meningitis □ Toxoplasmosis
□ Hepatitis A / B / C □ Histoplasmosis □ MRSA □ Wound Infection
Other:____

Previous Surgeries:

____
____

Current Systemic Medications: (List below <u>or</u> bring a copy of pharmacy list)
Aspirin or Blood Thinners? **□ No** **□ Yes, please list below**

____
____
____

Height: ____________ **Weight:** _______________

Have you ever had problems with Anesthesia? □ No □ Yes, reaction:______________________________

Have you ever taken prostate medicines or Alpha Blockers? □ No □ Yes, circle or list below

Flomax, Tamsulosin, Hytrin, Cardura, Saw Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo, Other:______________________

The questions below are required by the Government:

Have you ever had the Pneumonia Vaccine? □ No □ Yes

Have you had a Fall in the past year? □ No □ Yes

(D*efined as 2 or more falls in the past year OR a fall that resulted in injury in the past year)*

Family History: (Applies to gene or "blood" relation only)

□ Unknown Family History

□ Blindness	Relation:_____________________	□ Heart Disease	Relation:_________________________
□ Cancer	Relation:_____________________	□ High Blood Pressure	Relation:_________________________
□ Diabetes	Relation:_____________________	□ Keratoconus	Relation:_________________________
□ Glaucoma	Relation: ____________________	□ Macular Degeneration	Relation:_________________________

Social History: (Mark all that apply)

Smoking: □ every day smoker □ occasional smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes, list how much and how often?____

Recreational Drug Use: □ No □ Yes, list type and how often?____

Review of Systems: (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 Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

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

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ 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

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure