Triangle Ophthalmology

Medical History and Review of Systems Questionnaire

Name:_____ **Date of Birth:** _____ **Age:**_____ **Chart #:**_____
Medical Doctor:_____**Location:**_____ **Phone:**_____
Referring Doctor (if applicable)_____**Previous Eye Doctor:**_____

List all major illnesses including eye disease and injury that you have had:_____
_____
_____
List non eye related surgeries that you have had with the dates:_____ _____
_____
Have you or any blood relative had any complications from anesthesia: □ NO □ YES explain:

Eyes:
List eye conditions:
□ macular degeneration
□ glaucoma
□ diabetic retinopathy
□ cataracts
□ dry eye

Other:

Eye Surgeries and Dates:
Right Eye Left Eye

Other Systems	**YES**	**NO**	**Explanation**
Ears, Nose, Throat –Sinus &/or ear infections Or problems, chronic cough, dry mouth, etc.			
Cardiovascular – heart, disease, heart failure, heart surgery, bypass surgery, atrial fibrillation/ irregular heart beat, poor circulation, arteritis, etc			
Respiratory –asthma,emphysema, bronchitis, "COPD", etc			
Gastrointestinal – stomach or intestinal problems, Crohns, Ulcerative Colitis, scleroderma			
Genital, Kidney, Bladder – reiters, kidney stones or cysts, etc			
Muscles, bones, joints – arthritis, polymyalgia rheumatica, giant cell arteritis, connective tissue disease, etc			
Skin – skin cancer, rashes, lupus, unhealing sores, psoriasis, acne, rosacea, Raynauds, scleroderma, etc			
Neurological – stroke, TIA, carotid artery problems, migraines, headaches, multiple sclerosis, etc			□ migraines
Psychiatric – psychiatric disease, psychosis, anxiety, depression, etc			

Endocrine – hormone system Diabetes type 1 or 2 and duration Thyroid Problems (hyper or hypo)			□ Type 1 □ Type 2 Duration:_____
Blood/Lymphatic – anemia, sickle cell, thalesseia, high cholesterol, leukemia, lymphoma, etc			
Allergic/Immunologic- allergies, hay fever, lupus, HIV, Sjogrens, polyarteritis, Wegner's			
General Wellness: fever/chills/night sweats or other general problems not mention above			

Family History	**YES**	**NO**	M=Mother F=Father S=sibling G=Grandparent
Blindness (including night blindness)			At what age?
Glaucoma (if known, what type and age at onset)			
Migraine headaches			
Lazy Eye			
Crossed Eyes or misaligned eyes			
Macular Degeneration			
Retinal Detachment			
Corneal Disease			Name of condition?
Severe Nearsightedness (myopia)			
Retinal Disease			Name of condition?
Heart Disease			
Cancer			Type of cancer?
Any other Disease that runs in your family			

Patients under 15 years old:
Was the patient full term? □ Yes □ No, how premature? _____
Are the any developmental problems or delays?_____

Social History for Adults:
Are you employed? Yes, Current Occupation: _____
No, □unemployed □ student
Marital Status: □ married □ divorced/separated □ single □ widowed
Do you drive? □ yes □ no
Do you drink alcohol? □ yes □ no If yes: □ occasional □ 1 drink/day □2-3/day □ 4+/day
Do you smoke? □ yes □ no If yes: □ ½ pack/day □ 1 pack/day □1+pack/day

Social History for Children:
Who does the child live with? _____
What school does he/she attend?_____ What grade are they in?_____

Additional Questions for Everyone:
What is the reason for your visit today? □ routine Other:_____
When was your last eye exam?_____