**Advanced Ophthalmology Associates PLC**

# Medical Questionnaire

**Race**: __ American Indian or Alaska Native __ Asian __ Black or African American
__ Native Hawaiian or Other Pacific Islander __ White

**Ethnicity:** __Hispanic __Not Hispanic

**Preferred Language:** __English Other:_____

| **Allergies:** | **Reaction** | **Severity** |
|---|---|---|
| _____ | _____ | mild / moderate / severe |
| _____ | _____ | mild / moderate / severe |
| _____ | _____ | mild / moderate / severe |
| _____ | _____ | mild / moderate / severe |

**Past Ocular History: (Please mark all that apply)** __No history of eye problems

__ Cataracts
__ Diabetic Retinopathy
__ Dry Eyes
__ Glaucoma
__ Hyperopia (Far sighted)
__ Iritis
__ Keratoconus
__ Macular Degeneration
__ Myopia (Near sighted)
__ Optic Neuritis
__ Retinal Detachment
__ Amblyopia (Lazy eye)
__ Aphakia
__ Astigmatism

Other_____

**Ocular Surgeries: (Please mark all that apply)** __No prior ocular surgery

| **R - L** | **R - L** | **R - L** | **R - L** |
|---|---|---|---|
| __ __ Foreign Body Removal | __ __ Punctal Plugs | __ __ Laser | __ __Cataract Surgery |
| __ __ Blepharoplasty | __ __ Retinal Laser Surgery | __ __ RK | __ __ LASIK |
| __ __ Strabismus Surgery | __ __ Vitrectomy | __ __ Corneal Transplant | __ __ PRK |

Other_____

**Current Eye Medications: (Please list)**

_____ _____ _____
_____ _____ _____

**Other Medical History: ____ No history of illnesses**

__ Thyroid Disease
__ Anemia
__ Arthritis
__ Arrhythmia
__ Asthma
__ Cancer
__ Hepatitis A / B / C
__ Herpes Simplex
__ Congestive Heart Failure
__ COPD
__ Diabetes Type 1
__ Diabetes Type 2
__ Eczema
__ Hearing Loss
__ Herpes Zoster / Shingles
__ Histoplasmosis
__ Syphilis
__ Headache
__ High Blood Pressure
__ High Cholesterol
__ HIV/ AIDS
__ Kidney Disease
__ Kidney Stones
__ Liver Disease
__ Meningitis
__ MRSA
__ Lung Disease
__ Lupus
__ Migraine
__ Psychiatric Disorder
__ Skin Cancer
__ Stroke
__Toxoplasmosis

Other_____

Have you had the Influenza vaccine? Yes___ No___ Or the Pneumococcal vaccine? Yes___No___

**General Surgeries / Operations: (Please list)**

_____ _____ _____
_____ _____ _____
_____ _____ _____

**All medications with dosages including supplements: (Please list or give list to front desk to make a copy)**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Family History:** Please fill with abbreviations: GGP= Great Grand Parent, GP=Grand Parent, P=Parent, A=Aunt, U=Uncle, S=Sibling, C=Child

__ Arthritis
__ Blindness Reason:_____
__ Cancer
__ Cataracts
__ Diabetes
__ Glaucoma
__ Heart Disease
__ High Blood Pressure
__ Kidney Disease
__ Lazy Eye
__ Macular Degeneration
__ Retinal Disease
__ Stroke
__ TB

Other_____

**Social History: (Please mark all that apply)**

Smoking: __ current every day smoker __ current some day smoker __ former smoker/quit year____ __ never smoked

Alcohol Use: __ Yes __ No If yes, how much and how often?_____

Drug Use: __ Yes __ No If yes, what drug and how often? _____

**Review of Systems: (Please mark all that apply)**

Eyes
__ Previous Surgery
__ 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/Hepatitus

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

Muscular/Skeletal
__Stiffness
__Arthritis
__Joint Pain / Swelling

Skin
__Rash / Sores
__Lesions
__Hives / Eczema

Neurological
__Seizures
__Weakness / Numbness
__Tremors

Immunologic
__Hives
__Itching
__Runny Nose
__Sinus Pressure