CTEC Medical History Questionnaire

Name _____ Preferred Name _____ Date of Birth ____/____/____

Primary Care Physician: _____ Referring Doctor: _____

Pharmacy: _____ Location (street & city): _____

Race/Ethnicity: _____ Preferred Language: _____

Employer: _____ Occupation: _____

Have you been recently referred to our office? If yes, by whom?: _____

Reason for today's visit: _____

Allergies: Reaction Severity ☐ None Known

_____ Reaction Type _____ mild/moderate/severe

_____ Reaction Type _____ mild/moderate/severe

Past Ocular History: (Previous eye surgeries/laser/trauma/diagnoses) ☐ Overall Healthy

_____

_____

Current Eye Medications: (Please list) ☐ None

_____

_____

Past Medical History: ☐ No history of illness

☐ Heart Problems	☐ Hepatitis	☐ Lung Disease	☐ Lupus	☐ Anemia
☐ COPD	☐ High Blood Pressure	☐ Migraine	☐ Arthritis ☐ *Osteo*	☐ *Rheumatoid*
☐ Diabetes ☐ *Type I* ☐ *Type II*		☐ High Cholesterol	☐ Stroke	☐ Eczema
☐ HIV	☐ Psychiatric Disorder	☐ Asthma	☐ Fibromyalgia	☐ Thyroid
☐ Kidney Disease	☐ Multiple Sclerosis	☐ Headache	☐ Sjrogrens	☐ Liver Disease
☐ Cancer _____		☐ Hearing Loss		

Other _____

Infections: (Please mark all that apply) ☐ Overall Healthy

☐ Herpes Simplex	☐ HIV/AIDS	☐ Syphillis	☐ Chicken Pox
☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis	☐ Hepatits A / B / C
☐ Histoplasmosis	☐ MRSA	☐ Wound Infection	☐ Other _____

General Surgeries / Operations: (Please list) ☐ None

_____

_____

Current Systemic Medication and Dosage: (Please use back if need more space) (Include over-the-counter medications)

_____

_____

_____

Family History: ☐ None

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

Social History: (Please mark all that apply)

Smoking: ☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

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

Drug Use: ☐ Yes ☐ No If yes, how much and how often _____

Patient Signature: _____ Date _____

Review of Systems: (Please mark all that apply) ☐ None

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 Heartbeat
- ☐ 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 Easily
- ☐ 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

Patient Signature _____ Date _____