MID-SOUTH RETINA ASSOCIATES, LLC

MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

Patient Name: _____ Age: ____ Occupation: _____ Date:_____

Referring Physician: _____ Primary Care Doctor: _____

PAST MEDICAL HISTORY: (Circle)

Diabetes : type 1 type 2	High Blood Pressure	Heart Failure	Thyroid Disorder	Tuberculosis	Arthritis
Duration :_____	Heart Attack	Emphysema	AIDS/HIV	Lupus	Cancer
A_1C: _____	Stroke	Asthma	Leukemia	Lymphoma	Sarcoid
Last Glucose:_____					

LIST ANY MAJOR ILLNESSES: _____

List All Medications Currently Using: ☐ **List Provided and Attached**

Medicine	Dose	Times Per Day
1._____		1 2 3 4
2._____		1 2 3 4
3._____		1 2 3 4
4._____		1 2 3 4
5._____		1 2 3 4
6._____		1 2 3 4
7._____		1 2 3 4
8._____		1 2 3 4
9._____		1 2 3 4
10._____		1 2 3 4
11._____		1 2 3 4
12._____		1 2 3 4

Drug Allergies: (Circle)

Latex	Sulfa
Penicillin	Tetracycline
Aspirin	Cipro
Contrast Dye	Iodine

Other Allergies: _____

_____

_____

_____

Circle any of the surgical procedures patient has had and list any additional surgeries not circled in space provided.

Tonsillectomy	Hysterectomy (removal uterus/ovaries)
Prostate Surgery	Heart Bypass
Gall Bladder Removal	Lumbar Discectomy (back surgery)

Anesthetic Complications: Yes No

Cataract Surgery: Right Left

Retina Reattachment: Right Left

Other Surgeries:_____

_____

_____

Hospitalizations:_____

For:_____

Eyes:	**Yes**	**No**	**Right**	**Left**
Loss of Vision	☐	☐	☐	☐
Loss of Vision (<5 minutes)	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐
Distorted Vision (straight lines crooked)	☐	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	☐
Previous Eye Disease or Treatment:_____	☐	☐		

	Yes	**No**	**Right**	**Left**
Floaters	☐	☐	☐	☐
Flashes of Light	☐	☐	☐	☐
Loss of Side Vision	☐	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐	☐
Double Vision				
Burning	☐	☐	☐	☐
Lazy Eye/Amblyopia	☐	☐	☐	☐

Does visual problem affect daily activities? (Explain)_____

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REVIEW OF RECENT HEALTH (SYSTEMS)

Constitutional Symptoms	**Yes**	**No**
Fever/Chills	☐	☐
Weight Loss	☐	☐
Fatigue	☐	☐
Night Sweats	☐	☐

Rheumatology	**Yes**	**No**
Lyme Disease	☐	☐
Other	☐	☐

Describe:_____

_____

Ear, Nose, Throat, Mouth	**Yes**	**No**
Sinus Congestion	☐	☐
Sore Throat	☐	☐
Runny Nose	☐	☐
Cold Sore Lip/Mouth	☐	☐
Cardiovascular	☐	☐
Chest Pain (Angina)	☐	☐
Rapid Heartbeat	☐	☐
Heart Skips Beat	☐	☐
Short of Breath Walking	☐	☐
Enlarged Heart	☐	☐
Respiratory (Breathing/Lungs)	☐	☐
Cough	☐	☐
Difficulty Breathing	☐	☐
Asthma Attacks	☐	☐
Allergy	☐	☐
Seasonal Allergies	☐	☐
GU (Kidney/Bladder/Genitals)	☐	☐
Blood in Urine	☐	☐
Burns to Urinate	☐	☐
Sores on Genitals	☐	☐
Kidney Stones	☐	☐
Renal Failure	☐	☐
Dialysis	☐	☐

GI (Stomach/Intestines)	**Yes**	**No**
Diarrhea	☐	☐
Constipation	☐	☐
Blood in BM	☐	☐
Cramps/Pain	☐	☐
Skin	☐	☐
Tick Bites	☐	☐
Rashes	☐	☐
Reproductive	☐	☐
Pregnant	☐	☐
Last Menstrual Period	_____	
Neuro	☐	☐
Loss of Balance	☐	☐
Headaches	☐	☐
Weakness Arm/Leg	☐	☐
CVA/Stroke	☐	☐
Numbness of Arm/Leg	☐	☐
Seizure Disorder	☐	☐
Hematologic (Blood/Lymph)	☐	☐
Anemia (Low Blood Count)	☐	☐
Abnormal White Blood Cells	☐	☐
Swollen Lymph Nodes	☐	☐
Bleeding Disorder	☐	☐
Sickle Cell Disorder	☐	☐

FAMILY HISTORY	**Yes**	**No**	**Relationship to Patient**
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Attacks	☐	☐	_____
High Blood Pressure	☐	☐	_____
Tuberculosis	☐	☐	_____
Stroke	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Married **Yes**_____ **No**_____

Do you use drugs for pleasure? **Yes**_____**No**_____

SMOKING STATUS (Circle)

Current smoker Chewing nicotine product

Former smoker Previous history of Chewing tobacco

Never smoked Using nasal snuff

Current every day smoker

Current some day smoker

Attempting to quit using chewing tobacco

Recently quit using chewing tobacco

Patient Signature:_____ **Date:** _____

_____**(For office use below)**_____

Physician Signature:_____ Date: _____

Tech Update: Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____

Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____