CTEC Medical History Questionnaire

Name: ______________________________________ **Nickname**: ___________________________ **Date of Birth**: ____/____/______

Primary Care Physician: _________________________________ **Referring /Specialty Dr.** _______________________________

Pharmacy: ____________________________________ **Location** (street & city) ____

Race/Ethnicity: ____________________________ □ Defer **Preferred Language:** ______________________________

Employer: ____ **Occupation:** _______________________

Were you referred to our office? If so, by whom ____________________________________

Reason for today's visit: ____

Allergies: ____ **Reaction Severity** □ **None**

__________________________ Reaction Type ________________ mild / moderate / severe

__________________________ Reaction Type _________________ mild / moderate / severe

Past Ocular History: (Previous surgeries/lasers/trauma/diagnoses) □ **Overall Healthy**

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Current Eye Medications: (Please list) □ **None**

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Past Medical History: □ **No history of illnesses**

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

Infections: (Please mark all that apply) □ **Overall Healthy**

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

General Surgeries / Operations: (Please list) □ **None**

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Current Other Medications and dosage: (Please list-use back if need more room) (including over the counter medications)

□ **None** ____

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Family History: □ **None**

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

Social History: (Please mark all that apply)

Smoking: □ current every day 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 what and how often? ____

(other than prescribed medications)

PATIENT SIGNATURE: ____ **DATE**: ___________________