MINNESOTA EYE CONSULTANTS, P.A.

OFFICE USE ONLY
PN: _____
DOS: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth**: _____

Vision Correction – Do you wear glasses? ☐ No ☐ Yes Do you wear contact lenses? ☐ No ☐ Yes

Reason(s) for Visit – In your own words, please describe the reason for your visit today:

_____

_____

Visual Function Questions – Please check if you are experiencing difficulty with any of the following:

No	Yes		No	Yes	
		Reading Small Print			**Watching Television**
		Reading Traffic or Street Signs			**Driving at Night**
		Driving in Bright Light			**Seeing Steps, Curbs or Stairs**
		Glare or Halo			**Floaters or Flashes**
		Dry, Red, Sandy or Itchy Feeling			**Other:**

Allergies – Please list all known medication (including intravenous contrast dye and anesthetics) and environmental (including seasonal, food and latex) allergies or indicate ☐ NO KNOWN ALLERGIES.

Allergy	Reaction	Allergy	Reaction

Current Medications – Please list all current prescribed medications (including eye drops and medical cannabis), over-the-counter medications, vitamins and supplements or indicate ☐ NO MEDICATIONS.

Name	Dosage	Frequency	Name	Dosage	Frequency

Review of Symptoms – Please check if you are experiencing any of the following:

N	Y	Constitutional	N	Y	Cardiovascular	N	Y	Endocrine	N	Y	Integumentary
		Fatigue			Chest Pain/Pressure			Cold Intolerance			Hives
		Fever			Irregular Heartbeat			Heat Intolerance			Rash
N	**Y**	**HEENT**	**N**	**Y**	**Gastrointestinal**	**N**	**Y**	**Neurological**	**N**	**Y**	**Musculoskeletal**
		Bulging Eyes			Abdominal Pain			Imbalance			Back Pain
		Hearing Loss			Constipation/Diarrhea			Headache			Joint Stiffness
		Sinus Problems			Nausea/Vomiting			Memory Difficulty			Muscle Weakness
N	**Y**	**Respiratory**	**N**	**Y**	**Genitourinary**	**N**	**Y**	**Psychiatric**	**N**	**Y**	**Hematologic**
		Asthma			Pain with Urination			Depressed Mood			Bleeding
		Cough			Blood in Urine			Irritability			Bruising
		Wheezing									Tender Lymph Nodes

Current Height: _____ **Current Weight**: _____

Past Ocular and Surgical History – Please check if you have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type):

No	Yes		No	Yes	
		Cataract:			**Cornea:**
		Glaucoma:			**LASIK:**
		Oculoplastic:			**Retina:**
		Other:			**Other:**

Personal and Family Health History – Please check if you or a family member have / have had any of the following or indicate ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY.

	Self	Mother	Father	Sister	Brother
Allergies					
Anxiety					
Auto-Immune Disorder (note type)					
Blindness					
Cancer (note type)					
Cataracts					
Corneal Disease					
Diabetes (note type)					
Depression					
Glaucoma					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Lazy Eye					
Macular Degeneration					
Migraines					
Retinal Disease					
Seizure Disorder					
Stroke					
Thyroid Disorder					
Other:					
Other:					

Females: Are you currently pregnant? ☐ No ☐ Yes Are you currently breastfeeding? ☐ No ☐ Yes

Social History

Have you ever used tobacco? ☐ No ☐ Yes - If yes: ☐ Former ☐ Current Every Day ☐ Current Some Day

Tobacco Product: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/chew ☐ Smokeless ☐ Other: _____

Do you drink alcohol? ☐ No ☐ Former ☐ Yes - - If yes: ____ drinks per ☐ Day ☐ Week ☐ Month ☐ Year

Do you drink or consume caffeine? ☐ No ☐ Yes - - If yes: ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets

Occupation: _____ Status: ☐ Full Time ☐ Part Time ☐ Retired / Other