

Medical History Questionnaire

LAST NAME _____ MI _____ FIRST NAME _____

DATE _____ AGE _____ WHO REFERRED YOU? _____

1. What is your **OCCUPATION**? _____

2. What is the **MAIN REASON** for your visit? _____

3. Please list all known **ALLERGIES** to medications or LATEX: None See attached list
MEDICATION REACTION

4. Please list any **EYE PROBLEMS** you have or have had: None See attached list
 (For example: glaucoma, macular degeneration, cataract, lazy eye, strabismus, eye trauma, prism glasses, etc....)

5. Please list any **EYE SURGERY** you have had in the past: None See attached list
 (For example: glaucoma, cataract, retina, laser surgery, eyelid surgery, injections, etc....)

6. Please list all your **EYE DROPS**: None See attached list
NAME OF EYE DROP WHICH EYE(S) HOW OFTEN

7. Please list any **MEDICAL PROBLEMS** you have or have had: None See attached list
 (For example: high blood pressure, diabetes, heart disease, arthritis, etc.)

8. Please list any **SURGERIES** you have had: None See attached list

9. Please list all your **MEDICATIONS AND SUPPLEMENTS**: None See attached list

| | |
|---------------------------|------------------|
| <u>NAME OF MEDICATION</u> | <u>FREQUENCY</u> |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| 10. Current Immunizations | | |
|----------------------------------|--------------------------|--------------------------|
| | Yes | No |
| Flu | <input type="checkbox"/> | <input type="checkbox"/> |
| Covid-19 | <input type="checkbox"/> | <input type="checkbox"/> |
| Covid-19 Booster | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Shingles | <input type="checkbox"/> | <input type="checkbox"/> |

11. Does or did anyone in your **FAMILY** ever have any of the following?
 Glaucoma? ___ Yes ___ No Who? _____
 Macular Degeneration? ___ Yes ___ No Who? _____
 Blindness? ___ Yes ___ No Who? _____
 Diabetes? ___ Yes ___ No Who? _____

12. What is your **SMOKING** history?

| | | | |
|--|---|--|--|
| Current Every Day Smoker <input type="checkbox"/> | Current Some Day Smoker <input type="checkbox"/> | Former Smoker, Quit: _____ <input type="checkbox"/> | Never Smoked <input type="checkbox"/> |
|--|---|--|--|

South Bay Ophthalmology, Inc.

Edward J. Saub, M.D.
Eye Physician and Surgeon

Optical Shop

13. Describe your **ALCOHOL** consumption:

| | | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|--|
| <i>Never</i> <input type="checkbox"/> | <i>Rare</i> <input type="checkbox"/> | <i>On Occasion</i> <input type="checkbox"/> | <i>1 per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail | | | <i>2 per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail | | | <i>3 or more per day:</i> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> cocktail | | |
|--|---|--|--|--|--|--|--|--|--|--|--|

14. Circle your **RELATIONSHIP** status? *Single* *Married* *Domestic Partner* *Widowed* *Divorced*

15. What is your **PREFERRED LANGUAGE**? _____

16. Of the following choices, **WHICH BEST DESCRIBES YOU?** Please check one.

| | | | | | |
|--|--|---|---|--|---|
| <i>American Indian/Alaska Native</i> <input type="checkbox"/> | <i>Asian</i> <input type="checkbox"/> | <i>Black/African American</i> <input type="checkbox"/> | <i>Native Hawaiian/Pacific Islander</i> <input type="checkbox"/> | <i>Hispanic/Latino</i> <input type="checkbox"/> | <i>All Others</i> <input type="checkbox"/> |
|--|--|---|---|--|---|

17. Do you wear **GLASSES**? ___ Yes ___ No

18. Do you wear **CONTACT LENSES**? ___ Yes ___ No *How often?* _____ *Monovision?* Y / N **Near Eye:** R / L

What brand? _____

What power? Right: _____ Left: _____ *What base curve?* Right: _____ Left: _____

19. Please indicate whether or not you **CURRENTLY HAVE** any of the following symptoms or conditions listed:

| | Y | N | | Y | N | | Y | N |
|--------------------------|---|---|-------------------------------|---|---|------------------------|---|---|
| Eyes | | | Respiratory | | | Blood/Lymph | | |
| Previous Surgery | | | Cough | | | Easy Bruising | | |
| Contact Lens | | | Congestion | | | Gums Bleed Easily | | |
| Pain | | | Wheezing | | | Prolonged Bleeding | | |
| Double Vision | | | Asthma | | | Heavy Aspirin Use | | |
| Glaucoma | | | Tuberculosis | | | Autoimmune Disorder | | |
| Cataracts | | | Sinusitis | | | Lymphoma or Leukemia | | |
| Macular Degeneration | | | History of COVID-19 infection | | | | | |
| Dry Eyes | | | | | | | | |
| Flashes | | | Gastrointestinal | | | Musculoskeletal | | |
| Floaters | | | Heartburn | | | Stiffness | | |
| | | | Nausea/Vomiting | | | Arthritis | | |
| Ear, Nose, Throat | | | Jaundice/Hepatitis | | | Joint Pain/Swelling | | |
| Hard of Hearing | | | Dental Problems | | | Low Back Pain | | |
| Ringing in Ears | | | Crohn's Disease or Colitis | | | | | |
| Vertigo | | | | | | Skin | | |
| Sleep Apnea | | | Genito-Urinary | | | Rash/Sores | | |
| Excessive Dry Mouth | | | Pain/Difficulty | | | Lesions | | |
| Snoring | | | Blood in Urine | | | Hives/Eczema | | |
| Cardiovascular | | | History of Kidney Stones | | | | | |
| Chest Pain | | | History of STDs | | | Neurological | | |
| Dizziness | | | Kidney Disease | | | Seizures | | |
| Fainting Spells | | | | | | Weakness/Paralysis | | |
| Shortness of Breath | | | Psychiatric | | | Numbness | | |
| Irregular Heart Beat | | | Anxiety | | | Tremors | | |
| Difficulty Lying Flat | | | Depression | | | Headache or Migraine | | |
| Raynaud's Syndrome | | | Mood Swings | | | Multiple Sclerosis | | |
| Stroke | | | Difficulty Sleeping | | | | | |
| | | | Endocrine | | | Immunologic | | |
| Constitutional | | | Increased Thirst | | | Hives | | |
| Fatigue/Weakness | | | Increased Hunger | | | Itching | | |
| Fever | | | Increased Urination | | | Runny Nose | | |
| Weight Gain/Loss | | | Increased Sweating | | | Sinus Pressure | | |
| Night Sweats | | | Fingernail Changes | | | HIV | | |