# Martel Eye Medical Group

## Medical History Questionnaire

**What is the primary reason for your visit?**

_____

_____

_____

_____

**Please describe your problem further:**

Which eye(s)? _____ How long has it been present? _____

How severe is it (On a scale of 1 to 10, with 10 being the worst)? _____

What makes it better/worse? _____

Please list any associated symptoms (if applicable): _____

_____

**Are you currently having any of the following?**

Please specify which eye(s) and/or if you want to include any detail.

| | | |
|---|---|---|
| Loss of vision | Y / N | _____ |
| Blurred vision | Y / N | _____ |
| Distorted vision (halos) | Y / N | _____ |
| Loss of side vision | Y / N | _____ |
| Double vision | Y / N | _____ |
| Itching | Y / N | _____ |
| Mucous discharge | Y / N | _____ |
| Glare/light sensitivity | Y / N | _____ |
| Eye pain or soreness | Y / N | _____ |
| Chronic infection of eye/lid | Y / N | _____ |
| Stye or Chalazion | Y / N | _____ |
| Fluctuating visual acuity | Y / N | _____ |
| Tired eyes | Y / N | _____ |
| Dryness | Y / N | _____ |
| Redness | Y / N | _____ |
| Sandy or gritty feeling | Y / N | _____ |
| Burning | Y / N | _____ |
| Foreign body sensation | Y / N | _____ |
| Excess tearing/watering | Y / N | _____ |
| Flashes | Y / N | _____ |
| Floaters | Y / N | _____ |
| **Is this a work related injury?** | Y / N | If yes, are you presently back at work? Y / N |
| | | If no, do you feel you can return to work? Y / N |

**What medications are you currently taking?**
Please list the dosage if you know it.

_____ _____
_____ _____
_____ _____
_____ _____

**Are you allergic to any medications?**
Please list what happens when you take it.

_____ _____
_____ _____

**Please list any past/current medical history:**
Please list any surgeries along with approximate dates.

**Eyes, Ears, Nose, Mouth, Throat** Y / N _____
(cough, runny nose, etc.) _____

**Cardiovascular** Y / N _____
(heart, blood vessels) _____

**Respiratory** Y / N _____
(lungs, breathing) _____

**Genitourinary** Y / N _____
(kidney, bladder) _____

**Musculoskeletal** Y / N _____
(muscles, joints) _____

**Integument** Y / N _____
(skin, breast) _____

**Neurological** Y / N _____
(stroke, seizures, etc.) _____

**Psychiatric** Y / N _____
(anxiety, depression, etc.) _____

**Endocrine** Y / N _____
(diabetes, thyroid, etc.) _____

**Hematological/Lymphatic** Y / N _____
(blood, lymph nodes) _____

**Allergic/Immunologic** Y / N _____
(allergies, swelling) _____

Females: Are you currently pregnant? Y / N If yes, how many months? _____

# Family History

If you have any of the following, please mark the self box. If a family member has any of the following, please mark the yes or no box. Then indicate how you are related.

| Disease | Self | Yes | No | Relationship to Patient |
|---|---|---|---|---|
| Blindness | S | Y | N | _____ |
| Cataract | S | Y | N | _____ |
| Glaucoma | S | Y | N | _____ |
| Macular Degeneration | S | Y | N | _____ |
| Retinal Detachment | S | Y | N | _____ |
| Arthritis | S | Y | N | _____ |
| Cancer | S | Y | N | _____ |
| Diabetes (I or II) | S | Y | N | _____ |
| Heart Attacks | S | Y | N | _____ |
| High Blood Pressure | S | Y | N | _____ |
| Kidney Disease | S | Y | N | _____ |
| Lupus | S | Y | N | _____ |
| Sjögrens Syndrome (Dry Eyes) | S | Y | N | _____ |
| Stroke | S | Y | N | _____ |
| Thyroid Disease | S | Y | N | _____ |
| Tuberculosis | S | Y | N | _____ |
| Hepatitis (A, B, C) | S | Y | N | _____ |
| Other | S | Y | N | _____ |

## Social History

What is your current occupation? _____

| | | |
|---|---|---|
| Do you drive? | Y / N | _____ |
| Do you have difficulty when driving? | Y / N | _____ |
| Do you have problems with night vision? | Y / N | _____ |
| Do you wear contact lenses? | Y / N | _____ |
| Do you wear glasses? | Y / N | _____ |
| When was your last prescription? | Y / N | _____ |
| Do you drink alcohol? | Y / N | _____ |
| If yes, how much and how often? | | _____ |
| Do you smoke? | Y / N | _____ |
| If yes, how much and how often? | | _____ |
| Do you use recreational drugs? | Y / N | _____ |
| If yes, how much and how often? | | _____ |
| Are you HIV positive? | Y / N | _____ |
| Have you ever had a blood transfusion? | Y / N | _____ |

Patient's signature: _____ Date: _____

History Reviewed _____