



**THE EYE CLINIC
OF NORTH DAKOTA**

A Tradition with Vision

History and Information Questionnaire

PATIENT NAME: _____ DATE: _____

CHART NUMBER: _____

Please answer the following questions regarding your medical history and current health status. (Please mark all that apply).

Primary Doctor: _____

Referring Doctor: _____

Past Medical History:

A. Have you ever had any eye disease?

- Glaucoma Cataracts Wandering or Lazy Eye Retinal Problems
- Macular Degeneration None Other

B. Please check **ALL PREVIOUS EYE SURGERIES**

- Cataract Corneal Transplant Eye Muscle Surgery Radial Keratotomy None
- YAG Laser LASIK/PRK Trabeculectomy Other

C. Have you ever been treated for any of the following medical history?

- Hypertension Heart Disease Lung Disease Hypercholesterolemia
- Diabetes Arthritis Stroke Kidney Stones/Disease
- IDDM/NIDDM Asthma Liver Disease Other Cancer roid
- Hepatitis None

D. Please check all previous general surgeries

- Nose Surgery Tonsils Adenoids Ear Surgery/Tubes
- Thyroid Surgery Jaw Surgery Mastectomy Knee Replacement
- Breast Biopsy Hysterectomy Back Surgery Colon/Bowel Surgery
- Appendectomy Hernia Gallbladder None
- Prostate Bladder Surgery Hip Replacement
- Heart Surgery Foot Surgery Other

E. PLEASE LIST ALL CURRENT EYE MEDICATIONS AND DOSAGES, IF ANY

None

F. PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES, IF ANY

None

G. Do you have any allergies or adverse reactions to medications? Please list allergies if yes.

Yes No

Family History:

H. Do any medical or eye diseases run in your **IMMEDIATE FAMILY**?

- Cancer Diabetes Heart Disease Hypertension
Cataracts Glaucoma Macular Degeneration None
Other

Social History:

I. Do you smoke or have a history of smoking? Yes No

If yes, year started year quit

J. Marital Status:

- Married Single Divorced Widowed Separated Partner

K. Alcohol Usage:

- None Occasional/Social 1-2 Drinks/day 3-4 Drinks/day

L. Occupation:

- Retired Working Not Working Disabled Occupation:

M. Driving:

- Yes No

N. History of Falling:

- No Yes 1 or More Falls in Current Year No Falls in the Current Year
No Falls in the Past Year Two or More Falls or Fall with Injury in the Past Year Not Ambulatory

Review of Symptoms:

Do you **CURRENTLY** have any of the following symptoms? **PLEASE CHECK ALL THAT APPLY.**

1. ALLERGY/IMMUNOLOGY

- Negative Autoimmune Disease Seasonal Allergies Unspecified

2. CARDIOVASCULAR

- Negative Chest Pain Shortness of Breath Swelling of the Feet
Shortness of Breath when Laying Flat Racing Pulse Irregular Heartbeat
Blood Pressure Stable Blood Pressure Uncontrolled No Shortness of Breath
No Chest Pain No Chest Pain or Shortness of Breath

3. CONSTITUTIONAL

- Negative Fever Weight Loss Fatigue Loss of Appetite Chills
Unexplained Weight Loss Night Sweat Feels Sick Poor Appetite
No Fevers, Fatigue, or Weight Loss

4. ENDOCRINE

- Negative Excessive Thirst Excessive Urination Heat Intolerance Cold Intolerance
Hair Loss Dry Skin Blood Sugars Poorly Controlled Blood Sugars Stable
Unsure of Glycemic Control

5. GASTROINTESTINAL

- Negative Abdominal Pain Nausea Diarrhea Bloody Stools
Stomach Ulcers Constipation Trouble Swallowing Gastrointestinal Ulcers

Jaundice or Yellow Skin

6. GENTOURINARY

Negative Pain/Burning on Urination Blood in Urine Bladder Trouble Dialysis
 Genital Sores or Ulcers Kidney Failure Kidney Problems Kidney Stones
 Prostatitis Testicular Pain Urinary Discharge

7. HEMATOLOGY/ONCOLOGY

Negative Easy Bruising Prolonged Bleeding

8. HENT

Negative Hearing Loss Sore Throat Runny Nose Dry Mouth Jaw Claudication
 Earache

9. INTEGUMENTARY

Negative Rash Change in Mole Rashes Skin Sores Skin Cancer
 Severe Itching Loss of Hair

10. MUSCULOSKELETAL

Negative Muscle Aches Joint Pain Difficulty Lying flat due to Musculoskeletal Discomfort
 Back Pain While Sleeping or Awakening

11. NUROLOGICAL

Negative Weakness Headaches Scalp Tenderness Dizziness
 Paralysis of Extremities Tremor Stroke Numbness
 Numbness or Tingling in the Body Seizures or Convulsions Fainting

12. PSYCHIATRIC

Negative Denies ADD, ADHD, anxiety, depression, or behavioral problems ADHD
 Anxiety Bipolar Disorder Alzheimer's/Dementia Confusion Depression

13. RESPIRATORY

Negative Wheezing Cough Coughing Up Blood Severe or Frequent Colds
 Difficulty Breathing No Cough or Wheezing

Have you ever been exposed to any infectious disease such as Hepatitis, Aids, or Tuberculosis?

Yes No If yes, please

explain _____

Have you had any prior problems or reactions to local or general anesthesia? Yes No

If yes, please

explain _____

SIGNATURE: _____ **DATE:** _____
