

Medical History Questionnaire

Matthew Y. Matsuzaki, OD

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Guardian (if applicable): _____

Race: _____ Ethnicity: _____

Name of Medical Doctor: _____

Address: _____ Dr.'s Phone: _____

Last Medical Exam: _____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications (including oral contraceptives, aspirin, over the counter medications, and home remedies, or vitamins): _____

List all major injuries: _____

List all major surgeries and/or hospitalizations: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injuries: _____

Are you pregnant? no yes nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contacts lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended wear Other: _____

Are they comfortable? no yes Do you experience problems with dryness? no yes

Family History

Please note any family history (parents, grandparents {maternal or paternal}, siblings, children, living or deceased) for:

Disease/Condition	NO	YES	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*please turn this form over and continue

Social History

Name: _____

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? no yes Do you have visual difficulty when driving? no yes

If yes, please describe: _____

Tobacco Use: never smoked former smoker *stopped: within last year, 1-2yrs, 3-4yrs, 4-5yrs, 5+yrs, 10+yrs
 current everyday smoker current someday smoker current smokeless tobacco user
 smoker, current status unknown

Alcohol Use: none social use only 1 - 2 drinks daily
 above average use alcohol dependency

Narcotic Use: none recreational chemical dependency

Have you ever been exposed to or infected with: HIV Hepatitis Gonorrhea Syphilis

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

	NO	YES		NO	YES
Constitutional			Ears, Nose, Mouth, Throat		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Eyes			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	Vascular / Cardiovascular		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	Bones / Joints / Muscles		
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye / Lid	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazions	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic		
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain and list medications: _____

Doctor's Signature _____

Date: _____