MEDICAL HISTORY QUESTIONNAIRE PAGE 1
this information will become part of your confidential medical record

MABEE EYE CLINIC
MITCHELL, SD 57301
(605) 996-2537

PATIENT NAME: _____DATE OF BIRTH:_____DATE COMPLETED: _____
Address: _____ Phone number: _____
City: _____ State:_____ Zip _____

MEDICAL HISTORY

Do you have any **allergies** to medications? YES NO If yes, please list: _____
_____

Do you have a history of **MRSA**? (infections resistant to antibiotics) YES NO DON'T Know

MEDICATIONS: List all medications you take (including oral contraceptives, aspirin, and over the counter medications) You may attach a separate sheet. _____
_____
_____

MY OWN MEDICAL HISTORY (PERSONAL MEDICAL)

Do you have, or have you had the following?			If yes, when did it start?
Arthritis	YES	NO	
Asthma (breathing problems)	YES	NO	
Cancer	YES	NO	
COPD (lung disease)	YES	NO	
Heart Disease	YES	NO	
High Cholesterol	YES	NO	
High Blood Pressure	YES	NO	
Kidney Disease	YES	NO	
Thyroid Problems	YES	NO	
Diabetes/Diet Controlled	YES	NO	Date Diagnosed?
Diabetes/Controlled by pills	YES	NO	Date Diagnosed?
Diabetes/Insulin Dependent	YES	NO	Date Diagnosed?

List any Injuries or Hospitalizations and Dates: _____
_____

List any Surgeries and Dates: _____
_____
_____

MY EYE HISTORY (OCULAR)			If yes, when did it start?
Glaucoma	YES	NO	
Cataract	YES	NO	
Macular Degeneration	YES	NO	
Eye Injuries	YES	NO	
Retinal Disease	YES	NO	
Blindness	YES	NO	
Lazy Eye (Strabismus)	YES	NO	
Cross Eyes (Esotropia/Exotropia)	YES	NO	
Diabetic Retinopathy	YES	NO	How long? _____
Dry Eye	YES	NO	
I wear glasses	YES	NO	All the time/Part time
I wear contact lenses	YES	NO	Daily wear/Extended wear
I work on a computer	YES	NO	How many hours per day? _____

Social History

Marital Status (circle one) Single Married Widowed Divorced Other_____
Employment: _____
Hobbies: _____
Tobacco Products (circle one)
Never a smoker/Former smoker (quit)/Currently a smoker/Chews Tobacco/Ex-tobacco chewer

Alcohol (circle one)
Never drinker/Currently do not drink/Social Drinker/
1-2 drinks a day/3-6 drinks a day/7-9 drinks a day/9 or more drinks a day

MEDICAL HISTORY QUESTIONNAIRE PAGE 2 this information will become part of your confidential medical record

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PATIENT NAME: _____ DATE COMPLETED: _____
DATE OF BIRTH: _____

HEALTH HISTORY (FAMILY)	Circle all that apply				Other
Glaucoma	Father	Mother	Brother	Sister	
Cataract	Father	Mother	Brother	Sister	
Macular Degeneration	Father	Mother	Brother	Sister	
Retinal Tears or Detachment	Father	Mother	Brother	Sister	
Ocular Disease	Father	Mother	Brother	Sister	
Blindness AND/OR vision impairment	Father	Mother	Brother	Sister	
Strabismus (Crossed Eyes)	Father	Mother	Brother	Sister	
Amblyopia (Decreaed Vision)	Father	Mother	Brother	Sister	
Diabetes Mellitus	Father	Mother	Brother	Sister	
Cancer	Father	Mother	Brother	Sister	
Cardiovascular (Heart) Disease	Father	Mother	Brother	Sister	
Hypertension (high blood pressure)	Father	Mother	Brother	Sister	
Hypercholesterolemia (high cholesterol)	Father	Mother	Brother	Sister	
Kidney Disease	Father	Mother	Brother	Sister	
Stroke	Father	Mother	Brother	Sister	

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas? Please Circle.

CONSTITUTION
- Fever YES NO
- Weight Loss YES NO
- Weight Gain YES NO

CARDIOVASCULAR
- Fainting Spells YES NO
- Slow Heart Beat YES NO
- Irregular Heart Beat YES NO
- High Blood Pressure YES NO
- High Cholesterol YES NO

EARS, NOSE, MOUTH,THROAT
- Sinus YES NO
- Ear Infection YES NO
- Runny Nose YES NO
- Post-Nasal Drip YES NO
- Chronic Cough YES NO
- Dry Throat/Mouth YES NO

RESPIRATORY
- Wheezing YES NO
- Chronic Cough YES NO
- Shortness of Breath YES NO
- Asthma/Emplysema YES NO

GASTROINTESTINAL YES NO
- Diarrhea YES NO
- Intestinal Problems YES NO

GENITOURINARY
- Problems Urinating YES NO
- Prostate Problems YES NO

MUSCULOSKELETAL
- Rheumatoid Arthritis YES NO
- Muscle Pain YES NO
- Joint Pain YES NO

INTEGUMENTARY/SKIN
- Dry Skin YES NO
- Skin Lesions YES NO

NEUROLOGICAL
- Headaches YES NO
- Dizziness YES NO
- Numbness/Weakness of Arms or Legs YES NO

PSYCHIATRIC
- Depression YES NO
- Anxiety YES NO

ENDOCRINE
- Insulin Dependent Diabetes YES NO
- Non-Insulin Dependent Diabetes YES NO
- Thyroid YES NO

HEMATOLOGIC/LYMPHATIC
- Bleeding Problems YES NO
- Bruise Easily YES NO

ALLERGIC/IMMUNOLOGIC
- Get infections easily YES NO
- Seasonal Allergies YES NO

EYES
- Blurred Vision YES NO
- Distorted vision/halos YES NO
- Loss of Side Vision YES NO
- Double Vision YES NO
- Dryness YES NO
- Mucous Discharge YES NO
- Redness YES NO
- Sandy or Gritty Feeling YES NO
- Itching YES NO
- Burning YES NO
- Foreign Body Sensation YES NO
- Excess Tearing/Watering YES NO
- Flashes/Floaters in Vision YES NO
- Glare/Light Sensitivity YES NO
- Chronic Eye/Lid Infection YES NO
- Styes or Chalazion YES NO
- Loss of Vision YES NO