Julia D. Katz, MD, PLLC

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ Date of Birth: _____ Today's Date: _____

Have you ever had any of the following medical problems?

Cataracts	Y	N	Glaucoma	Y	N
Retinal Detachment	Y	N	Crossed/Turned Eyes	Y	N
Dry Eyes	Y	N	Headache	Y	N
High blood pressure	Y	N	Heart disease	Y	N
High cholesterol	Y	N	Diabetes mellitus	Y	N
Asthma	Y	N	Emphysema	Y	N
Breathing problems	Y	N	Cancer	Y	N
Thyroid disease	Y	N	Autoimmune disease	Y	N
Arthritis	Y	N	Gastrointestinal disease	Y	N
Prostate disease	Y	N	Keloids/excessive scars	Y	N

Other: _____

Do you currently take any medications? Y N

If Yes, please list: _____

_____

Are you allergic to any medication or food? Y N

If Yes, please list: _____

Do you wear glasses? Y N

Do you wear contact lenses? Y N

If Yes, soft or hard? _____ Brand: _____

For women only:

Are you pregnant? Y N Are you nursing? Y N

Do you ***currently*** have any problems in the following areas?			
If YES, please provide information.	**YES**	**NO**	**Details**
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia**)**			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD (anemia, clotting abnormality, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY	M = mother F = father S = sibling GP = grandparent		
Disease	**YES**	**NO**	**Relationship to Patient**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY							
Current occupation:							
Education (high school, vocational school, college degree):							
Marital status (married, divorced, single, widowed):							
Living arrangements:							
Do you drive?			**YES**	**NO**			
Do you have visual difficulty when driving?			**YES**	**NO**			
Do you have problems with night vision?			**YES**	**NO**			
Do you drink alcohol?	**YES**	**NO**	If YES:	occasional	1/day	2-3/day	4+/day
Do you smoke?	**YES**	**NO**	If YES:	occasional	½ pack/day	1 pack/day	1+ pack/day

Physician's Signature: _____ *Date:* _____