CHARLOTTE EYE EAR NOSE & THROAT ASSOCIATES, P.A.

Medical History Questionnaire (EYE)

Patient Name: _____ **Today's Date**: _____
Last First MI

Birth date: _____ **Age**: _____ **Gender**: ☐ Male ☐ Female **Accompanied by**: _____

Primary Care Physician: _____ **Referring Doctor**: _____

Reason for Visit: _____

Pharmacy Name: _____ **Pharmacy Location:** _____

Drug Allergies: ☐ Yes ☐ No If yes, list drug allergies and how you reacted: _____

List of current medications: _____

Surgical History

Have you had any of the following procedure? Please check all that apply.

☐ Brain Surgery ☐ Cataract Removal/IOL Implant ☐ Corneal Transplant ☐ Cosmetic Surgery ☐ Eye Lid Surgery
☐ Glaucoma Surgery ☐ Refractive Surgery ☐ Strabismus Surgery ☐ Laser ☐ Pterygium
☐ Tear Duct Surgery ☐ Retina Surgery

Comment(s): _____

Ocular History

Have you had or do you currently have any of the following conditions? Please check all that apply

☐ Amblyopia ☐ Bell's Palsy ☐ Cataracts ☐ Corneal Ulcer ☐ Diabetic Retinopathy
☐ Double Vision ☐ Eye Trauma ☐ Glaucoma ☐ Headache / Migraine ☐ Herpes Zoster
☐ High Blood Pressure ☐ Keratitis ☐ Macular Degeneration ☐ Nystagmus ☐ Optic Atrophy
☐ Optic Neuritis ☐ Refractive Error ☐ Retinal Detachment ☐ Retinal Hemorrhage ☐ Retinitis Pigmentosa
☐ Retinoblastoma ☐ Seasonal Allergies ☐ Shingles ☐ Sjogren's Syndrome ☐ Strabismus
☐ Unequal Pupil Size ☐ Uveitis

Comment(s): _____

Medical History

Have you had or do you currently have any of the following conditions? Please check all that apply.

☐ Acid Reflux ☐ Anemia ☐ Aneurysm ☐ Arthritis ☐ Asthma
☐ Autoimmune Disease ☐ Bleeding Problem ☐ Cancer ☐ Anesthesia Complications ☐ COPD
☐ Diabetes ☐ Hepatitis ☐ Heart Failure ☐ HIV/AIDS ☐ Kidney Disease
☐ Nerve / Muscle Disease ☐ Sickle Cell Disease ☐ Stroke

Comment(s): _____

Family History

Please check any of the following diseases/conditions that any of your blood relatives have been diagnosed with.

☐ Albinism ☐ Amblyopia ☐ Anesthesia Problems ☐ Autoimmune Disease ☐ Blindness
☐ Cancer ☐ Diabetes ☐ Fuchs' Dystrophy ☐ Glaucoma ☐ Hypertension
☐ Macular Degeneration ☐ Retinal Detachment ☐ Strabismus ☐ Stroke ☐ Thyroid Disease
☐ Unknown

Comment(s): _____

Social History

Tobacco Use

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Never ☐ Former Smoker
☐ Passive ☐ Heavy Smoker ☐ Light Smoker

Smokeless Tobacco Use

☐ Current User ☐ Never Used ☐ Former User

Comments on your history with tobacco: _____

Alcohol Use: ☐ Yes ☐ No *Drug Use*: ☐ Yes ☐ No

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Medical History Questionnaire (EYE)

Review of Systems

Please check all systems which you currently have, or have had recently. If Yes, please explain these symptoms in the comment section. If you have not experienced a medical problem under the symptom listed, please check the No box.

Constitutional Symptoms (ex: fatigue, fever, difficulty sleeping) ☐ Yes ☐ No
Comment: _____

Gastrointestinal Symptoms (ex: nausea, heartburn, difficulty swallowing) ☐ Yes ☐ No
Comment: _____

Neurological Symptoms (ex: speech difficulties, migraines, dizziness, headaches, seizures) ☐ Yes ☐ No
Comment: _____

Integument (Skin) Symptoms (ex: new skin lesions, lumps, change in mole appearance) ☐ Yes ☐ No
Comment: _____

Genitourinary Symptoms (ex: urgency, pain or burning with urination, kidney stones) ☐ Yes ☐ No
Comment: _____

Musculoskeletal Symptoms (ex: muscular weakness, twitching, joint pain) ☐ Yes ☐ No
Comment: _____

Head, Ear, Nose, or Throat Symptoms (ex: hearing loss, snoring) ☐ Yes ☐ No
Comment: _____

Endocrine Symptoms (ex: weight gain, weight loss, history of thyroid problems) ☐ Yes ☐ No
Comment: _____

Cardiovascular Symptoms (ex: chest pain, irregular heartbeats) ☐ Yes ☐ No
Comment: _____

Eye Symptoms (ex: eye discomfort, changes in vision) ☐ Yes ☐ No
Comment: _____

Respiratory Symptoms (ex: shortness of breath, hoarseness, cough) ☐ Yes ☐ No
Comment: _____

Psychiatric Symptoms (ex: anxiety, depression) ☐ Yes ☐ No
Comment: _____

Allergic-Immunologic Symptoms (ex: environmental allergies, immune deficiency) ☐ Yes ☐ No
Comment: _____

Heme (Blood)-Lymph Symptoms (ex: swollen lymph nodes, easy bleeding or bruising) ☐ Yes ☐ No
Comment: _____

Activities of Daily Living

Are you deaf or do you have serious difficulty hearing?
☐ Yes ☐ No

Are you blind or do you have serious difficulty seeing, even when wearing glasses?
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
☐ Yes ☐ No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)
☐ Yes ☐ No

Do you have difficulty dressing or bathing? (5 years old or older)
☐ Yes ☐ No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (5 years old or older)
☐ Yes ☐ No

Travel Screening

Have you traveled outside the U.S. within the last 3 months?
☐ Yes ☐ No If so, where? _____

Form Completed By: _____ **Effective Date:** _____ ***Entered Into Epic?*** _____