Anne K. Matsushima, O.D., Inc. Today's date:_____

Medical History Questionnaire

Last name:_____ **First name:**_____ **MI:**_____ **Date of birth:**_____

Patient Ocular History: Please indicate if you have or have ever been diagnosed with the following conditions or symptoms.

☐ Blurred vision	☐ Dry eyes	☐ Flashes	☐ Cataracts	☐ Discharge from eyes
☐ Eyestrain	☐ Teary eyes	☐ Floaters	☐ Amblyopia (lazy eye)	☐ Temporary loss of vision
☐ Double vision	☐ Red eyes	☐ Eye pain/irritation	☐ Strabismus (eye turn)	☐ Macular degeneration
☐ Blindness	☐ Itchy eyes	☐ Retinal disease	☐ Glaucoma	☐ Eye injury

Eye surgery (type and date): _____

Other: _____

Date of last eye exam:_____ Doctor's name:_____ Were your eyes dilated? ☐ No ☐ Yes

Do you currently wear contact lenses? ☐ No ☐ Yes: Type? ☐ Hard/Gas Permeable, ☐ Soft, ☐ Multifocal . Cleaning Solution:_____
Right eye: Brand:_____ Power:_____ Base Curve (BC): _____
Left eye: Brand:_____ Power:_____ Base Curve (BC): _____

Are you interested in laser refractive surgery? ☐ No ☐ Yes

Patient Medical History: Please indicate if you have ever been diagnosed with the following medical conditions.

☐ High blood pressure	☐ High cholesterol	☐ Rheumatoid disease	☐ Diabetes: Date diagnosed _____ last HA1c & when? _____
☐ Headaches	☐ Heart disease	☐ Thyroid disease	☐ Cancer: type _____

Surgeries (type and date): _____

Other: _____

Medications: Please list the name, dosage, and frequency for all medications currently taken, including eye drops, supplements and OTC medications.

_____

_____

Allergies: Do you have any allergies? If yes, please list all food, drug, and any other allergies you may have.

☐ No ☐ Yes:_____

Review of Systems: Do you currently or have you recently had any of the following conditions? If yes, please explain.

Constitution (e.g. chronic fever, recent weight loss or gain, fatigue)..... ☐ No ☐ Yes:_____

Cardiovascular (e.g. chest pain, irregular heart beat, high blood pressure)..... ☐ No ☐ Yes:_____

Ears, Nose, Mouth, Throat (e.g. hearing loss, sinus, vertigo, dry mouth)..... ☐ No ☐ Yes:_____

Respiratory (e.g. shortness of breath, wheezing, coughing, asthma, congestion)..... ☐ No ☐ Yes:_____

Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, vomiting, ulcers)..... ☐ No ☐ Yes:_____

Genitourinary (e.g. pain or discomfort, blood in urine, prostate problems)..... ☐ No ☐ Yes:_____

Musculoskeletal (e.g. muscle ache, joint pain, swollen joints, arthritis)..... ☐ No ☐ Yes:_____

Integumentary (e.g. rash, excessive dryness, hives, acne)..... ☐ No ☐ Yes:_____

Neurological (e.g. numbness, weakness, headaches, paralysis, strokes)..... ☐ No ☐ Yes:_____

Psychiatric (e.g. depression, anxiety, trouble sleeping)..... ☐ No ☐ Yes:_____

Endocrine (e.g. hypothyroid, hyperthyroid diabetes)..... ☐ No ☐ Yes:_____

Hematologic/Lymphatic (e.g. elevated cholesterol, anemia, enlarged lymph glands) ☐ No ☐ Yes:_____

Allergic/Immunologic (e.g. hay fever, Lupus, Sjogren's, HIV/AIDS)..... ☐ No ☐ Yes:_____

Social History:

Do you smoke? ☐ No: ☐ Never smoked -or- ☐ Former smoker
☐ Yes: How often? ☐ Daily -or- ☐ Some days. How much? ☐ ½ pack, ☐ 1 pack, ☐ other:_____

Do you use recreational drugs? ☐ No ☐ Yes, Drug used:_____ Frequency:_____

Do you drink alcohol? ☐ No ☐ Yes, Frequency: ☐ Daily, ☐ Social, ☐ On occasion. How much?_____

Hobbies/Avocation:_____

Level of education (high school, vocational school, college, BA, BS, graduate degree, etc):_____

Do you have special visual needs?_____

Family History: Please indicated if there is a family history of the following medical conditions.

Indicate the relationship to patient: M = mother F = father B = brother S = sister GM = grandmother GF = grandfather U = uncle A = aunt

Glaucoma	_____	Retinal Disease	_____	Diabetes	_____	Arthritis	_____
Cataracts	_____	Blindness	_____	Cancer	_____	Thyroid Disease	_____
Macula Degeneration	_____	Strabismus	_____	Heart Disease	_____	Stroke	_____
Eye Injury	_____	Amblyopia	_____	Hypertension	_____	High Cholesterol	_____
Other eye conditions	_____			Other conditions	_____		