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	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other	☐	☐	☐	

***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 ☐ yphilis

Review of Systems:

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

Constitutional	NO	YES
Fever	☐	☐
Weight Loss / Gain	☐	☐
Integumentary (skin)	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision / Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing / Watering	☐	☐
Glare / Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye / Lid	☐	☐
Sties or Chalazions	☐	☐
Flashes / Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid / Other Glands	☐	☐
High Cholesterol	☐	☐

Ears, Nose, Mouth, Throat	NO	YES
Allergies / Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat / Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular / Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitourinary		
Genitals / Kidney / Bladder	☐	☐
Bones / Joints / Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic / Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic	☐	☐
Immunologic	☐	☐
Psychiatric	☐	☐

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

Doctor's Signature Date: