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

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

Medical History Questionnaire (EYE)

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?*** _____