Name: _____

DOB: _____

Bruce D. Gilliland, O.D.
Frank A. Carusone, O.D.
Heather R. West, O.D.

Medical History Questionnaire – please complete this form to the best of your knowledge

MEDICAL HISTORY

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation (irregular heartbeat)
- ❑ Bone Marrow Transplant
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Other

MEDICAL SURGERIES

- ❑ None
- ❑ Appendix: Appendectomy
- ❑ Bladder: Cystectomy
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (right / left / both breasts)
- ❑ Breast: Mastectomy (right / left / both breasts)
- ❑ Colon: Colectomy (Cancer Resection / Diverticulitis)
- ❑ Colon: Colonoscopy
- ❑ Gallbladder: Cholecystectomy
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement: Hip (right / left / both)
- ❑ Joint Replacement: Knee (right / left / both)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Kidney: Nephrectomy
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries: Oophorectomy (Endometriosis / Cancer / Cyst / Tubal Litigation)
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate: Prostatectomy (Prostate Biopsy / Cancer / TURP
- ❑ Rectum: APR
- ❑ Rectum: Low Anterior Resection
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Spleen: Splenectomy
- ❑ Testicles: Orchiectomy
- ❑ Uterus: Hysterectomy (Fibroids / Uterine Cancer)

_____

_____

_____

_____

EYE HEALTH HISTORY

- ❑ None
- ❑ Conjunctivitis (allergic / bacterial)
- ❑ Blepharitis (right / left / both)
- ❑ Cataract (right / left / both)
- ❑ Contact Lenses
- ❑ Corneal Dystrophy (right / left / both)
- ❑ Diabetic Retinopathy, Background (right / left / both)
- ❑ Diabetic Retinopathy, Proliferative (right / left / both)
- ❑ Dry Eyes
- ❑ Eye Infection (right / left / both)
- ❑ Glasses
- ❑ Glaucoma (right / left / both)
- ❑ Macular Degeneration (right / left / both)
- ❑ Macular ERM (right / left / both)
- ❑ Narrow Angles (right / left / both)
- ❑ Ocular Hypertension (right / left / both)
- ❑ Ophthalmic Migraine
- ❑ Pseudoexfoliation
- ❑ Retinal Tear (right / left / both)
- ❑ Strabismus (right / left / both)
- ❑ PVD (right / left / both)
- ❑ Other

_____
_____

EYE SURGERIES

- ❑ None
- ❑ Blepharoplasty (right / left / both)
- ❑ Cataract Surgery (right / left / both)
- ❑ Corneal Transplant (right / left / both)
- ❑ DSAEK (right / left / both)
- ❑ Eye Muscle Surgery (right / left / both)
- ❑ Intravitreal Injections (right / left / both)
- ❑ LASIK (right / left / both)
- ❑ LPI (right / left / both)
- ❑ LPT (right / left / both)
- ❑ PRK (right / left / both)
- ❑ Ptosis Repair (right / left / both)
- ❑ Punctal Plugs (right / left / both)
- ❑ Strabismus Surgery (right / left / both)
- ❑ Retinal Laser (right / left / both)
- ❑ Trabeculectomy (right / left / both)
- ❑ Tube Shunt (right / left / both)

❑ If eye surgery: which eye was done & when the surgery was performed: _____
_____
_____

Medications _____
_____
_____
_____
_____

Allergies _____
_____
_____

SOCIAL HISTORY

Smoking Status

- ❑ Never Smoke
- ❑ Current every day smoker
- ❑ Former smoker

Drug Status

- ❑ None
- ❑ Drug Use

Alcohol Status

- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day

Driving Status

- ❑ Not Driving
- ❑ Drives in daytime
- ❑ Drives at night

Additional Details

- ❑ None
- ❑ I feel safe at home
- ❑ I do not feel safe at home

DEVELOPMENTAL HISTORY – for Pediatric Patients Only

Birth	Activity	Speech	Motor Development
❑ Normal	❑ Normal	❑ Normal	❑ Normal
❑ Premature	❑ Hyperactive	❑ Difficulties	❑ Reduced motor skills
❑ Low Birth Weight	❑ Learning Difficulties	❑ Babbles	❑ Autism
❑ Complications	❑ Becomes Irritable	❑ Non-verbal	❑ Mentally Challenged

FAMILY HISTORY	**Mother:**	**Father:**	**Sister:**	**Brother:**	**Grandmother:**	**Grandfather:**	**Aunt:**	**Uncle:**
Arthritis	❑	❑	❑	❑	❑	❑	❑	❑
Blindness	❑	❑	❑	❑	❑	❑	❑	❑
Cataract	❑	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑	❑	❑	❑
Retinal Detachment	❑	❑	❑	❑	❑	❑	❑	❑
Retinitis Pigmentosa	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑
Lupus	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑	❑	❑	❑

_____
_____

If Cancer, please give all details of who & what type _____
_____
_____
_____

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s/technicians to examine, diagnose, and initiate treatment as deemed appropriate. I attest that I am of sound mind and in good mental health to have filled out this medical history form for myself or on behalf of the minor seeking medical services to the best of my knowledge. I further attest that I am the parent or legal guardian of the minor and have the authority to authorize care and treatment.

_____ Today's Date: ____/____/_____
Patient Signature / Minor's Printed Name

_____
Signature of Parent/ Legal Guardian

_____ Date Signed Off: ____/____/_____
Doctor's Signature