Ronit Kahanowicz, MD

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ Date of Birth: _____

Today's Date: _____

Have you been diagnosed with any of the following eye problems?

Cataracts	Yes / No	Glaucoma	Yes / No
Crossed/turned eyes	Yes / No	Macular degeneration	Yes / No
Dry Eye	Yes / No	Retinal detachment	Yes / No

Other: _____

Have you been diagnosed with any of the following medical problems?

		If yes, additional information:
Arthritis	Yes / No	_____
Asthma / Lung diseases	Yes / No	_____
Autoimmune disease	Yes / No	_____
Cancer	Yes / No	_____
Diabetes Mellitus	Yes / No	_____
Gastrointestinal disease	Yes / No	_____
Headache	Yes / No	_____
Heart disease	Yes / No	_____
High blood pressure	Yes / No	_____
High cholesterol	Yes / No	_____
Keloids/excessive scarring	Yes / No	_____
Prostate disease (men)	Yes / No	_____
Thyroid disease	Yes / No	_____

Other: _____

NAME: _____ ***DOB*:** _____

Do you currently take any medications? **IF** Yes, please list:

_____

_____

_____

Do you take any vitamins, supplements or herbal remedies: **IF** Yes, please list:

_____

Are you **allergic** to any medication or food? Yes / No

If Yes, please list:

Medication/food: _____ reaction: _____

Medication/food: _____ reaction: _____

Do you wear glasses? Y N

Do you wear contact lenses? Y N

If Yes, **soft** or hard?

Brand: _____

Do you drive**:** Yes / No

If Yes, do you have visual difficulty when driving? Yes / No

Do you have problems with night vision? Yes / No

Do you drink alcohol? Yes / No

If Yes, please choose: occasional 1/day 2-3/day 4+/day

Do you smoke? YES / NO

If Yes, please choose: occasional 1⁄2 pack/day 1 pk/day **1+** pack/day

For women only:

Are you pregnant? Yes / No

Are you breast feeding? Yes / No

NAME: _____ ***DOB:*** _____

FAMILY HISTORY: M = mother, F = father, S = sibling, GP = grandparent

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT (** M, F, S, GP **)**
Blindness			
Glaucoma			
Macular degeneration			
Autoimmune disease			
Arthritis			
Cancer (type)			
Diabetes			
Heart disease or high blood pressure			
Stroke			
Thyroid disease			
Other			

Do **YOU** ***currently*** have any symptoms in the following areas? If **yes**, please provide information.

EYES	**YES**	**NO**	**DETAILS**
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision/ haloes			
Glare/light sensitivity			
Loss of peripheral vision			
Double vision			
Crossed/lazy eye			
Dry eyes			
Mucous discharge			
Redness/Sandy/gritty feeling			
Itching			
Excessive tearing			
Eye pain or soreness			

NAME: _____ DOB: _____

Do **YOU *currently*** have any symptoms in the following areas? If yes, please provide information.

GENERAL MEDICAL	**YES**	**NO**	**Details**
General/Constitutional *(fever, weight loss, other)*			
Ears, Nose, Throat *(nasal congestion, ear ache, dry mouth, other)*			
Cardiovascular *(high blood pressure, racing pulse, other)*			
Respiratory *(cough, shortness of breath, wheezing, other)*			
Gastrointestinal *(reflux, gastritis, other)*			
Genito-Urinary *(prostate disease, urination disorder, impotence, other)*			
Musculoskeletal *(joint pain, stiffness, swelling, cramping, other)*			
Skin *(cancer, rosacea, rash, growths, other)*			
Neurological *(headache, stroke, numbness, other)*			
Psychiatric *(anxiety, depression, other)*			
Endocrine *(diabetes, thyroid, other)*			
Blood *(anemia, clotting abnormality, other)*			
Allergy *(itching, sneezing, tearing, hives, other)*			

Physician's Signature: _____ Date: _____

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