LAKELAND
OPHTHALMOLOGY

973.331.0300
3799 Route 46 Parsippany, NJ 07054
RIGHT NEXT TO TGI FRIDAY'S

Medical History Questionnaire

Today's Date ____________________

Name ____ **Birth Date** ______________________

Do you presently have any problem in these areas? If yes, please explain

Integument (skin)	Yes	No	_______________
Head	Yes	No	_______________
Eyes	Yes	No	_______________
Ears, nose, mouth, throat	Yes	No	_______________
Neck	Yes	No	_______________
Bones, joints (arthritis)	Yes	No	_______________
High Blood pressure	Yes	No	_______________
Kidney Disease	Yes	No	_______________
Thyroid Disease	Yes	No	_______________
Prostrate Disease	Yes	No	_______________
Respiratory (lungs breathing, Asthma, Bronchitis)	Yes	No	_______________
Cardiovascular (heart/blood vessels)	Yes	No	_______________
Neurological system (e.g. stroke)	Yes	No	_______________
Lympharies (lymph nodes, swelling)	Yes	No	_______________
Hematopoietic (Blood)	Yes	No	_______________
Allergic and immunologic	Yes	No	_______________
Infectious (e.g. AIDS, Hepatitis)	Yes	No	_______________
Psychiatric	Yes	No	_______________
Diabetes	Yes	No	_______________
Gastrointestinal (stomach, liver)	Yes	No	_______________

Medications you take: name, dosage, how many times a day.
(Include Vitamins, Herbal and over the counter meds)______________________________________

____

Surgeries and hospitalizations you have had in the past: ______________________________________

____

Major illnesses and/or injuries you have had in the past. ______________________________________

____

Do you have any allergies to medications Yes No ______________________________________

Are you allergic to latex? Yes No **Are you allergic to tape? Yes NO**

Are you allergic to shell fish, iodine or iodine preparations? Yes No

Any other allergies?____

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Family History:

What is the health status or cause of death of your parents, siblings or children?______________________

____

Any diseases in the family? If yes, indicate relationship to patient.

Condition	Yes	No	Relationship
Blindness	Yes	No	____________________________
Cataract	Yes	No	____________________________
Glaucoma	Yes	No	____________________________
Macular Degeneration	Yes	No	____________________________
Retinal Detachment	Yes	No	____________________________
Arthritis	Yes	No	____________________________
Cancer	Yes	No	____________________________
Diabetes	Yes	No	____________________________
Heart Attacks	Yes	No	____________________________
High Blood Pressure	Yes	No	____________________________
Kidney Disease	Yes	No	____________________________
Stroke	Yes	No	____________________________
Thyroid Disease	Yes	No	____________________________
Other	Yes	No	____________________________

Social History:

Present Occupation? ____

Question	Yes	No	
Do you drink alcohol?	Yes	No	If yes how many glasses a day ________
Do you smoke?	Yes	No	If yes how many pack / cig a day?________
Do you have an advance Directive /Living Will?	Yes	No	

Do You:

Question	Yes	No
Wear glasses	Yes	No
Wear contact lenses	Yes	No
Bleed excessively	Yes	No
Cough regularly	Yes	No
Have Chest Pain	Yes	No
Get short of breath	Yes	No
Sleep on more than one pillow	Yes	No
Have problems with urine	Yes	No
Have problems with digestion	Yes	No

Primary Care Physician ____ **Phone** ____________________

Referring Physician ____ **Phone** ____________________