Welcome to THOM DINH OD, LLC

MEDICAL HISTORY QUESTIONNAIRE

(All information is strictly confidential)

Updated 08/11/15-HL

Name _____Date of Birth_____ Date _____

How did you hear about us? _____

Have you ever been seen here before? YES NO

OCULAR HISTORY

Last eye exam: _____

From Doctor: _____

Have you ever had your eyes dilated?

YES NO YEAR:_____

Do you currently wear:

Glasses Contacts Glasses & Contacts None

Are you interested in wearing contact lenses?

YES NO

Have you ever worn contact lenses?

YES NO

Are you **currently experiencing** any of the following problems with your eyes? (CHECK ALL THAT APPLY)

- ☐ Blurred Vision
- ☐ Loss of Vision
- ☐ Loss of Side Vision
- ☐ Distorted Vision/Halos
- ☐ Double Vision
- ☐ Tired Eyes
- ☐ Flashes of lights
- ☐ Floaters in Vision
- ☐ Glare/Light Sensitivity
- ☐ Dryness
- ☐ Sandy/Gritty Feeling
- ☐ Foreign Body Sensation
- ☐ Burning
- ☐ Itching
- ☐ Redness/"Pink" Eye
- ☐ Excess tearing/Watering
- ☐ Eye Pain/Soreness
- ☐ Mucous Discharge
- ☐ Chronic infection of eye/lid
- ☐ Styes/Chalazion
- ☐ Other: _____

Have you been **diagnosed** with any of the following ocular problems? (CHECK ALL THAT APPLY)

- ☐ Cataracts
- ☐ Crossed Eyes
- ☐ Dry Eye
- ☐ Eye Injury/Trauma
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Lazy Eye/Amblyopia
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Disease
- ☐ Other: _____

List any **eye medications** you are currently taking (include over the counter artificial tears, eye vitamins):

_____

MEDICAL HISTORY

Last medical exam: _____From Doctor: _____

List all medications you take (include oral contraceptives, aspirin, over the counter meds, herbal meds):

_____

_____

_____

Are you allergic to any medications/others? YES NO If yes, explain: _____

List all major injuries, surgeries and/or hospitalizations: _____

_____

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following areas? (CHECK ALL THAT APPLY)

CARDIOVASCULAR/CARDIAC
- ☐ Arteriosclerosis
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss/Gain

EARS, NOSE, MOUTH, THROAT
- ☐ Allergy/Hay Fever
- ☐ Cough/Runny/nose/URTI
- ☐ Dry Throat/Mouth
- ☐ Sinus Congestion

FEMALES
- ☐ Pregnant
- ☐ Nursing

GASTROINTESTINAL
- ☐ Diarrhea/Constipation
- ☐ IBS/Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY
- ☐ Genitals/Kidney/Bladder
- ☐ Ovarian/Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

IMMUNOLOGIC
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Multiple Sclerosis (MS)
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome

INTEGUMENTARY (Skin)
- ☐ Acne
- ☐ Acne Rosacea
- ☐ Easy Bruising
- ☐ Growths
- ☐ Rashes
- ☐ Skin Cancer

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Muscle Pain

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Memory Loss

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Sleep Apnea

ENDOCRINE
- ☐ Thyroid Disease
- ☐ Diabetes

Duration of Diabetes: _____ Blood Sugar Level: _____ HgA1C:_____Endocrinologist:_____

If you have a condition not listed, please explain: _____
_____

FAMILY HISTORY

☐ OR CHECK HERE IF FAMILY HISTORY IS UNKNOWN

	RELATION TO YOU		RELATION TO YOU
☐ Blindness	_____	☐ Cancer	_____
☐ Cataract	_____	☐ Diabetes	_____
☐ Crossed/Lazy Eyes	_____	☐ Heart Disease	_____
☐ Glaucoma	_____	☐ High Blood Pressure	_____
☐ Macular Degeneration	_____	☐ Stroke	_____
☐ Retinal Detachment/Dz	_____	☐ Thyroid Disease	_____
☐ Arthritis	_____		

☐ Other Inheritable Disease:_____

SOCIAL HISTORY

What is your occupation? _____

What are your hobbies? _____

Do you use tobacco products? YES NO If yes, type/amount/how long? _____
Do you drink alcohol? YES NO If yes, type/amount/how long? _____
Do you use recreational drugs? YES NO If yes, type/amount/how long? _____