Medical History Questionnaire

Family Name

Given Name

Middle Name

Date of Birth (DD/MM/YY)

Gender
☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with partner

Race:
☐ White ☐ Asian ☐ Afro-Caribbean ☐ Other

Address

City

County

Post Code

Phone:

Home

Mobile

Work

Email:

NHS Number (If known):

Hospital Number (If Known):

Emergency Contact
Name:

Phone:

Relationship:

Employer:

Occupation:

General Practitioner (Name and Practice)

Opticians

Who Can we thank for your referral?

How do you plan to pay for your visit?

Self ☐
Insurance ☐
Member No.
Authorization No.

Allergies

	Yes	No
Iodine:	☐	☐
Latex:	☐	☐
Sticky Plasters	☐	☐

Medications:

Name	Reaction

Other Allergies (food, dust, hay-fever, etc.)

Substance:	Reaction:

Current Medications

	Yes	No		Yes	No
Warfarin	☐	☐	Aspirin	☐	☐ Check Box
Clpidogrel	☐	☐	Alpha Blockers	☐	☐

Other Medications:

Name:	Dose	Route
1.		
2.		
3.		
4.		

Past Medical History

Ophthalmic History

	Yes	No
Overall Healthy	☐	☐
Astigmatism	☐	☐
Iritis	☐	☐
Contact lenses	☐	☐
Retinal Detachment	☐	☐
Far Sighted (hyperopia)	☐	☐
Near Sighted (myopia)	☐	☐
Keratoconus	☐	☐
Optic Neuritis	☐	☐
Current Blepharitis	☐	☐
Glaucoma	☐	☐
cataract	☐	☐
Diabetic Retinopathy	☐	☐
Age Related macular degeneration	☐	☐
Amblyopia (lazy eye)	☐	☐

Previous Ophthalmic Surgeries

	Yes	No
No Surgeries	☐	☐
Blepharoplasty	☐	☐
Trabeculectomy	☐	☐
Corneal transplant	☐	☐
Strabismus Surgery	☐	☐
RK/PRK/Lasik	☐	☐
Refractive Surgery	☐	☐
Retinal Surgery	☐	☐
Foreign Body Removal	☐	☐
Cataract Surgery	☐	☐
Vitrectomy	☐	☐
Punctal plugs	☐	☐

Cardiovascular History

	Yes	No
Angina	☐	☐
High Blood Pressure	☐	☐
Ischemic Heart Disease	☐	☐
Heart Attack	☐	☐
Arrhythmia	☐	☐
Raynauds	☐	☐
Peripheral Vascular Disease	☐	☐
Pacemaker	☐	☐
Shortness of Breath with Exercise	☐	☐
Shortness of Breath while lying flat	☐	☐
Coronary artery Stints or Bi-pass Grafts	☐	☐

Neurologic History

	Yes	No
Anxiety	☐	☐
Claustrophobia	☐	☐
Confusion	☐	☐
Epilepsy	☐	☐
Dementia	☐	☐
Fits	☐	☐

Respiratory History

	Yes	No
Current Cough	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐

Other Medical History

	Yes	No
Overall Health	☐	☐
Herpes Simplex	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Multiple Sclerosis	☐	☐
Sjogren's Syndrome	☐	☐
Skin Cancer	☐	☐
Anaemia	☐	☐
Blood loss/low blood pressure	☐	☐
Arthritis	☐	☐

	Yes	No
Backache	☐	☐
History of MRSA	☐	☐
Infectious Disease	☐	☐
Fibromyalgia	☐	☐
Kidney Disease	☐	☐
Kidney Stones	☐	☐
Congestive Heart Failure	☐	☐
High Cholesterol	☐	☐
Eczema	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Polymyalgia Rheumatica	☐	☐
Hearing Loss	☐	☐
Thyroid Disease	☐	☐

Diabetic History

	Yes	No
Are you Diabetic?	☐	☐

Type? (1,2 or other) ______

Controlled by:

- Diet ☐
- Tablets ☐
- Insulin injections ☐
- Incretin Injections ☐
- Insulin pump ☐

Age at Diagnosis: ______ Duration of disease (years)? ______

Diagnosis Year: ______

Social History

	Current	Past	Never
Smoking	☐	☐	☐

packs per day ☐

Number of Years smoked ☐

Year Stopped ☐

	Current	Past	Never
Alcohol	☐	☐	☐

Units per week ☐

	Current	Past	Never
Substance Use	☐	☐	☐

	Current	Past	Never
Driving	☐	☐	☐

Vehicle type (car, heavy goods, motorcycle, etc.) ☐

Who lives in the home with you? ☐