CLAUDIO S. CONTRERAS, M.D., INC. **DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY**
2120 McKee Road
San Jose, CA 95116

MEDICAL HISTORY QUESTIONNAIRE

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If " YES", give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
1. Loss of or blurred vision	[ ]	[ ]	_____
2. Itching, burning, or discharge	[ ]	[ ]	_____
3. Redness	[ ]	[ ]	_____
4. Gritty feeling, dryness or tearing	[ ]	[ ]	_____
5. Glare/light sensitivity, or halos	[ ]	[ ]	_____
6. Eye pain or soreness	[ ]	[ ]	_____
7. Infection of eye, or eyelids, styles	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/nails/hair)	[ ]	[ ]	_____
Neurological (stroke/headaches)	[ ]	[ ]	_____
Psychiatric (depression/anxiety)	[ ]	[ ]	_____
Endocrine (hormones)	[ ]	[ ]	_____
Hematologic/ Immunologic (blood /infection)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY(EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	_____
			_____
			_____
Allergies to eye drops	[ ]	[ ]	_____
History of cataract, glaucoma	[ ]	[ ]	_____
History of crossed/ lazy eye	[ ]	[ ]	_____
History of eye injury or inflammation	[ ]	[ ]	_____
History of eye surgery	[ ]	[ ]	_____
History of retinal disease	[ ]	[ ]	_____

Name: _____Date of birth_____

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PAST HISTORY (MEDICAL)

List any medicines (other than eye drops) that you are currently using: _____
_____
_____
List all major illnesses: ___Diabetes ___High Blood Pressure __High Cholesterol__Arthritis
Other: _____
_____
List any major surgeries or operations: _____
_____
Do you have any allergies to medicines? **[ ]** NO **[ ]** YES
List: _____
Any other information_____

FAMILY HISTORY

	YES	NO	EXPLANATION/ RELATIONSHIP
OCULAR			
Blindness	**[ ]**	**[ ]**	_____
Cataract	**[ ]**	**[ ]**	_____
Glaucoma	**[ ]**	**[ ]**	_____
Macular Degeneration	**[ ]**	**[ ]**	_____
Retinal detachment	**[ ]**	**[ ]**	_____
MEDICAL			
Diabetes, Hypertension, etc.	**[ ]**	**[ ]**	_____
Asthma, arthritis, etc.	**[ ]**	**[ ]**	_____
Other (list)	**[ ]**	**[ ]**	_____
			_____

SOCIAL HISTORY

OCULAR
Decreased vision causes problems with:
(Circle one) Driving Night Vision Reading Sports/ Outdoor activities Hobbies

GENERAL
Do you drink alcohol? How much? **[ ]** **[ ]** _____
Do you smoke? How much? **[ ]** **[ ]** _____
Have you ever had a blood transfusion? **[ ]** **[ ]** _____
Have you ever had a sexually transmitted disease (STD)?- [Some STDs can affect the eyes]
_____

Patient's signature: _____ Date: _____

History reviewed
Claudio S. Contreras M.D.
_____
Claudio S. Contreras, M.D.