Champlain Ophthalmology
6430 Rockledge Drive, Suite 270, Bethesda, MD 20817
Phone: 301 493 9600 Fax: 301 493 9235

PATIENT'S NAME_____ DATE_____

DATE OF BIRTH_____

MEDICAL HISTORY QUESTIONNAIRE

What is the purpose of your visit today?_____

_____

If a physician referred you to us, please indicate his/her name/telephone no:_____

Please indicate primary care doctor name & telephone no:_____

_____

List any ALLERGIES to any MEDICATIONS:

___NONE
_____
_____
_____
_____

LIST ALL major illnesses, injuries & onset dates:

_____
_____
_____
_____
_____

List ALL medications & eyedrops:

_____
_____
_____
_____
_____
_____
_____

Have you recently taken or are you currently taking:

YES	NO	
___	___	**Steroids**
___	___	**Imitrex**
___	___	**Accutane**
___	___	**Birth Control Pills**
___	___	**Antihistamines**
___	___	**Cordarone (amiodarone hydrochloride)**
___	___	**Herbal Supplements**

List ALL surgeries (including eyes):

_____
_____
_____
_____
_____
_____
_____

Glasses/Contact Lens Use:
Age of current glass prescription _____
Bifocal_____ **Single Vision**_____
Contact Lens Wear: Daily_____ **Extended**_____
Soft_____ **RGP**_____ **PMMA**_____
Current lenses are how old? _____
Date Last Worn_____
Problems with contacts?_____

Social History

Current Occupation_____
_____

Hobbies/Avocations_____
_____

Do you drive? YES NO
Difficulty driving? YES NO
Do you drink alcohol? YES NO
If yes, how often? Occasional 1/day
2-3/day 4+/day

Problems with night vision or glare?_____

Do you smoke? YES NO
If yes, how often? 1/day 2-3/day 4+/day

PLEASE COMPLETE BOTH SIDES OF FORM →

REVIEW OF SYSTEMS

EYES

	YES	NO
Loss of vision	____	____
Fluctuating vision	____	____
Blurred or distorted vision	____	____
Loss of side vision	____	____
Double or shadowy vision	____	____
Dryness	____	____
Sandy or gritty feeling	____	____
Excessive tearing	____	____
Crusty lashes	____	____
Mucous or discharge	____	____
Itching/burning	____	____
Eye pain	____	____
Styes or chalazions	____	____
Eye trauma	____	____
Eye disease	____	____

List:_____

_____

Lazy eye/amblyopia	____	____
Strabismus	____	____

OTHER_____

SKIN

Keloid scarring	____	____

ENDOCRINE

Diabetes	____	____
Thyroid	____	____

ALLERGIC/IMMUNOLOGIC

Environmental allergies	____	____
Sarcoma	____	____
Herpes	____	____
HIV	____	____

EARS, NOSE, MOUTH & THROAT

	YES	NO
Sinus/Congestion	____	____
Runny nose/post nasal drip	____	____
Chronic cough	____	____
Dry mouth/throat	____	____

CARDIOVASCULAR

Heart/Blood/Vessels	____	____
Hypertension	____	____

RESPIRATORY

Breathing/asthma	____	____
Chronic bronchitis	____	____

GASTROINTESTINAL

Stomach/Intestines	____	____

MUSCULOSKELETAL

Muscle/Joint pain	____	____
Loose joints/skin	____	____

NEUROLOGICAL

Stroke/Closed head injury	____	____

HEMATOLOGIC/LYMPHATIC

Blood	____	____
Lymph nodes	____	____
Swelling	____	____

HISTORY REVIEWED

___ No changes

___ Additions as noted above

_____

Physician's Signature

FAMILY MEDICAL HISTORY M=Mother F=Father S=Sibling GP=Grandparents

DISEASE	YES	NO	RELATIONSHIP	DISEASE	YES	NO	RELATIONSHIP
Blindness	____	____	_____	Arthritis	____	____	_____
Glaucoma	____	____	_____	Cancer	____	____	_____
Cataracts	____	____	_____	Diabetes	____	____	_____
Retinal Detachment	____	____	_____	Heart	____	____	_____
Cornea	____	____	_____	High Blood Pressure	____	____	_____
Macular Degeneration	____	____	_____	Sjogren's Syndrome	____	____	_____

_____ _____

Patient's Signature **Date**