

MEDICAL HISTORY QUESTIONNAIRE Name 姓名: _____ Date 日期: _____

Primary reason for today's (first) visit: _____

請告知此次來的原因

PAST HISTORY (MEDICAL)

過往的醫藥記錄

List all major illnesses (Circle): Diabetes 糖尿病 Hypertension 高血壓 HIV/AIDS 愛滋病 Other: _____
請告知是否有重大疾病(圈選):

List any major surgical procedures: _____
請告知是否動過手術

List any medications (other than eyedrops) that you are currently using: _____
請告知目前使用的藥物 (除了眼藥水)

Do you have any medication allergies? NO YES Penicillin 盤尼西林 Sulfa 磺胺
請問有沒有藥物過敏?

List other medication allergies: _____
請告知藥名:

PAST HISTORY (EYE) 是否曾有眼睛疾病	YES	NO	EXPLANATION 請解釋
History of cataract, glaucoma 白內障, 青光眼	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of cross/lazy eye 斜視, 弱視	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other eye illness 其它眼疾	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injury or other disease 眼部受傷	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery 眼部手術	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies to eye drops 對眼藥水過敏	<input type="checkbox"/>	<input type="checkbox"/>	_____

List drops you are allergic to 請告知導致過敏的眼藥水名:

Eye drops currently in use: (list) 請告知目前使用的眼藥

SOCIAL HISTORY

Occupation 職業 _____

	YES	NO	EXPLANATION 請解釋
OCULAR 視力問題			
Have you ever tried to wear contacts? 曾戴過隱形眼鏡嗎?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have problems with contacts? 若曾有戴隱形眼鏡, 是否有任何問題或異常?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Vision causes problems with:

有任何視力的問題嗎?

- Driving 開車時
- Night vision 晚上時
- Reading 看書時
- Sports/Outdoor activities 運動時

GENERAL 一般問題

Do you drink alcohol? How much per day? _____
請問有喝酒嗎? 一天約喝多少呢?

Do you smoke? 請問有抽煙嗎?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a blood transfusion? 請問曾有接受輸血嗎?	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY 家族病史

	YES	NO	EXPLANATION/RELATIONSHIP 請解釋疾病及關係
OCULAR 眼部疾病			
Blindness 眼盲	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract 白內障	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma 青光眼	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration 眼球黃斑退化	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment 視網膜剝落	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEDICAL 其它疾病	YES	NO	EXPLANATION/RELATIONSHIP 請解釋疾病及關係
Diabetes 糖尿病	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis, lupus, etc. 關節炎, 紅斑性狼瘡, 等...	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (list) 其它	<input type="checkbox"/>	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS:

Do you presently have any problems in the following areas? If "YES", give an explanation.
請問最近在以下各身體部位有否問題? 若有, 請解釋。

	YES	NO	EXPLANATION OF PROBLEM
Eyes 眼部			
Loss or blurred vision 喪失視力或視力模糊	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision, double vision 視野或複視問題	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching, burning, or discharge 癢, 灼熱感, 或分泌物問題	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness 眼睛紅	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gritty feeling, dryness or tearing 感覺有沙粒入眼或乾眼或淚水增多	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sensitivity, or halos 畏光或眩光	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness 眼痛或酸	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infection of eye lashes or lid, styes 眼瞼發炎或針眼	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, nose, mouth, throat 耳, 鼻, 口, 喉嚨	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular, (heart, blood vessels) 心血管	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines) 腸	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidney/bladder) 腎及泌尿生殖器	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (muscles/joints) 肌肉或關節	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integument (skin/breast) 皮膚或乳房	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological 神經上的疾病	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric 精神上的疾病	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (hormones, glands) 賀爾蒙或腺體	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/Immunologic (blood) 血液或免疫的疾病	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies (hay fever, etc.) 過敏 (例如, 花粉熱, 等等)	<input type="checkbox"/>	<input type="checkbox"/>	_____