Albert Lin, M.D. Ophthalmology Consultants **Phone: (832)767-5877**
9999 Bellaire Blvd Suite 760 Houston, TX 77036 **Fax: (832)767-5964**

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: Diabetes _____ Hypertension _____Other:_____
請告知是否有重大疾病: 糖尿病 高血壓 其它

_____

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 Sulfa
請問有沒有藥物過敏? 盤尼西林 磺胺

List other medication allergies: _____
請告知藥名:

_____

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

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?	[ ]	[ ]	_____
Did you have problems with contacts? 若曾有戴隱形眼鏡，是否有任何問題或異常?	[ ]	[ ]	_____

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? 請問有喝酒嗎?	[ ]	[ ]	How much per day? _____ 一天約喝多少呢?

Do you smoke? 請問有抽煙嗎?	[ ]	[ ]
Have you ever had a blood transfusion? 請問曾有接受輸血嗎?	[ ]	[ ]

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	[ ]	[ ]	_____
Cataract 白內障	[ ]	[ ]	_____
Glaucoma 青光眼	[ ]	[ ]	_____
Macular degeneration 眼球黃斑部退化	[ ]	[ ]	_____
Retinal detachment 視網膜剝落	[ ]	[ ]	_____
MEDICAL其它疾病	**YES**	**NO**	**EXPLANATION/RELATIONSHIP** 請解釋疾病及關係
Diabetes 糖尿病	[ ]	[ ]	_____
Arthritis, lupus, etc. 關節炎，紅斑性狼瘡，等…	[ ]	[ ]	_____
Other (list) 其它	[ ]	[ ]	_____

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	[ ]	[ ]	_____
Loss of side vision, double vision 視野或複視問題	[ ]	[ ]	_____
Itching, burning, or discharge 癢，灼熱感，或分泌物問題	[ ]	[ ]	_____
Redness 眼睛紅	[ ]	[ ]	_____
Gritty feeling, dryness or tearing 感覺有沙粒入眼或乾眼或淚水增多	[ ]	[ ]	_____
Glare/light sensitivity, or halos 畏光或眩光	[ ]	[ ]	_____
Eye pain or soreness 眼痛或酸	[ ]	[ ]	_____
Infection of eye lashes or lid, styes 眼瞼發炎或針眼	[ ]	[ ]	_____
Ears, nose, mouth, throat 耳，鼻，口，喉嚨	[ ]	[ ]	_____
Cardiovascular, (heart, blood vessels)心血管	[ ]	[ ]	_____
Respiratory (lungs/breathing)肺及呼吸道	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)腸胃	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder) 腎及泌尿生殖器	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)肌肉或關節	[ ]	[ ]	_____
Integument (skin/breast) 皮膚或乳房	[ ]	[ ]	_____
Neurological 神經上的疾病	[ ]	[ ]	_____
Psychiatric 精神上的疾病	[ ]	[ ]	_____
Endocrine (hormones, glands)賀爾蒙或腺體	[ ]	[ ]	_____
Hematologic/Immunologic (blood) 血液或免疫的疾病	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.) 過敏 **(**例如，花粉熱，等等**)**	[ ]	[ ]	_____