

Medical History Questionnaire:

(Please print clearly and use the back of this page if you need more space)

Today's date: _____

Name: _____

Your age: _____ Your birthplace: _____

Who is your medical doctor? _____

What is the main reason for your visit today?

Do you have any of these eye symptoms?

- | | |
|--|---|
| <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Glare, halos around lights |
| <input type="checkbox"/> Blurred reading vision | <input type="checkbox"/> Itching or burning eyes |
| <input type="checkbox"/> Blurred reading vision | <input type="checkbox"/> Eye mattering or tearing |
| <input type="checkbox"/> Constant double vision | <input type="checkbox"/> Foreign body sensation |
| <input type="checkbox"/> Flashing lights or floaters | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Dry eyes |

Have you ever had any of these eye problems?

- | | |
|--|--|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Serious eye injury |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Iritis/uveitis |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Lazy eye |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Wore eye patch as a child | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Hyperopia (Far sighted) |
| <input type="checkbox"/> Other: _____ | |

Please list any eye surgeries you have had:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> Cataract surgery | <input type="checkbox"/> Retinal laser surgery |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> Blepharoplasty surgery |
| <input type="checkbox"/> LASIK | <input type="checkbox"/> Trabeculectomy (glaucoma) |
| <input type="checkbox"/> RK | <input type="checkbox"/> Strabismus surgery (eye muscle) |
| <input type="checkbox"/> PRK | <input type="checkbox"/> Punctal plugs |
| <input type="checkbox"/> Foreign body removal | |

Which eye medications do you currently take?

None Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these conditions?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS, HIV | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Headaches _____ | | |

If you have glaucoma:

In what year was the diagnosis first made?

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you have any allergies to any medications?

None known Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____

Have members of your family had any eye disease?

(This would be your father, mother, sister, brother, grandparents)

- | | |
|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetic eye disease or diabetes |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Iritis/uveitis | <input type="checkbox"/> Blindness <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Poor vision <input type="checkbox"/> Other: _____ | |

What non-surgery illness have caused a hospital stay?

Please list any *other* surgeries you have had:

None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____

Which *other* medications do you currently take?

None Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Do you use:

Tobacco No Yes How much: _____

Alcohol No Yes How much: _____

If yes, how much? _____

What was the approximate date of your last eye examination: _____