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?

- ❑ Blurred distance vision
- ❑ Glare, halos around lights
- ❑ Blurred reading vision
- ❑ Itching or burning eyes
- ❑ Constant double vision
- ❑ Eye mattering or tearing
- ❑ Flashing lights or floaters
- ❑ Foreign body sensation
- ❑ Red Eyes
- ❑ Dry Eye
- ❑ Eye Pain

Do you have any allergies to any medications?

❑ None known ❑ Yes, which ones? (list below)

Medication Name	What reaction did you have?

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

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
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Have you ever had any of these eye problems?

- ❑ Cataract
- ❑ Serious eye injury
- ❑ Glaucoma
- ❑ Iritis/uveitis
- ❑ Macular degeneration
- ❑ Lazy eye
- ❑ Wore eye patch as a child
- ❑ Retinal detachment

Other: ____

Have you ever had any of these conditions?

❑ None

- ❑ Stroke
- ❑ Dizziness
- ❑ High blood pressure
- ❑ Arthritis
- ❑ Allergies
- ❑ Heart disease
- ❑ Diabetes
- ❑ AIDS, HIV
- ❑ Lung diseases
- ❑ Cancer
- ❑ Anemia
- ❑ Thyroid disease
- ❑ Headaches
- ❑ Other: _________________________

____

Have members of your family had any *eye* diseases?

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

- ❑ Glaucoma
- ❑ Diabetic eye disease or diabetes
- ❑ Cataract
- ❑ Crossed eyes
- ❑ Macular degeneration
- ❑ Iritis/uveitis
- ❑ Blindness
- ❑ Retinal detachment
- ❑ Poor Vision
- ❑ Other: _________________________

Please list any *eye* surgeries you have had:

❑ None

Type of Eye Surgery	Which Eye	Year
	Right Left	
	Right Left	
	Right Left	
	Right Left	

Please list any *other* surgeries you have had:

❑ None

Type of Surgery	Year

What non-surgery illness have caused a hospital stay?

____

____

____

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 use? ❑ Tobacco ❑ Alcohol

Would you like to wear contact lenses?

❑ Yes ❑ Not interested at this time.

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