MEDICAL HISTORY QUESTIONNAIRE

Patient ______________________ Date ______________

Street ______________________ Date of birth ______________

City, state, zip ______________________ Age ______________

Home phone ______________________ Place of birth ______________

Work phone ______________________ Occupation ______________

Referred by ______________________ Phone number ______________

Address ______________________

Medical doctor ______________________ Phone number ______________

Address ______________________

Eye doctor ______________________ Phone number ______________

Address ______________________

VISION HISTORY

Do you wear:

- YES NO glasses
- YES NO contact lenses
- YES NO an artificial eye

Have you ever had:

- YES NO cataract
- YES NO glaucoma
- YES NO diabetes
- YES NO lazy eye
- YES NO double vision
- YES NO decreased vision
- YES NO floaters
- YES NO halos
- YES NO flashing lights
- YES NO abnormal light sensitivity
- YES NO blind spots
- YES NO jagged lines in your vision
- YES NO poor side vision
- YES NO poor night vision
- YES NO poor color perception
- YES NO poor depth perception
- YES NO retinal problems
- YES NO poor blood supply to eye
- YES NO serious eye infection
- YES NO abnormal pupil
- YES NO other, if so, what?

EYE, LID, TEARING HISTORY

Do you have, or have you been treated for:

- YES NO dry eyes
- YES NO red eyes
- YES NO itchy eyes
- YES NO wet eyes
- YES NO overflowing tears
- YES NO eye that bulges
- YES NO pressure in/behind the eye
- YES NO lids/ lashes stick together
- YES NO pus around the eye
- YES NO crusting or red lids
- YES NO lazy or droopy lids
- YES NO lid retraction
- YES NO thyroid eye disease
- YES NO eye that turns in or out
- YES NO eye or eyelid growths
- YES NO spasms of the lids or face
- YES NO facial weakness or palsy
- YES NO eye, lid, or facial injury
- YES NO eye surgery, if so, what?
- YES NO other, if so, what?

FAMILY EYE HISTORY

Has anyone in your immediate family ever had:

- YES NO cataracts
- YES NO glaucoma
- YES NO diabetes
- YES NO macular degeneration
- YES NO retinal problems
- YES NO blindness from any cause
- YES NO hereditary eye problems
- YES NO other eye disorders, if so, what?

MEDICAL HISTORY

Do you have, or have you been treated for:

- YES NO diabetes
- YES NO high blood pressure
- YES NO low blood pressure
- YES NO thyroid problems
- YES NO lung problems
- YES NO bleeding problems
- YES NO hardening of the arteries
- YES NO strokes
- YES NO seizures
- YES NO myasthenia
- YES NO cancer
- YES NO skin cancer
- YES NO hepatitis
- YES NO asthma
- YES NO arthritis
- YES NO ulcers
- YES NO lupus
- YES NO multiple sclerosis
- YES NO heart problems, if so, what type:
- YES NO angina
- YES NO congestive heart failure
- YES NO myocardial infarction
- YES NO heart valve disease
- YES NO chest pain
- YES NO shortness of breath
- YES NO other heart disease, if so, what?

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- YES NO other medical problems, if so, what?

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SOCIAL HISTORY

- YES NO Do you smoke now? How much?
- YES NO Have you ever smoked? How many years? How much? When did you stop?
- YES NO Do you drink alcohol? How much? How often?
- YES NO Did you drink in the past? How much? How often?
- YES NO Have you ever used IV drugs?
- YES NO Are you pregnant?

SURGICAL HISTORY

- YES NO Have you ever had a reaction to *general* anesthesia?
- YES NO Have you ever had a reaction to *local* anesthesia?
- YES NO Have you ever had a blood transfusion? When?
- YES NO Have you ever had surgery or laser surgery? Please list any surgery you have had and the date:

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ALLERGIES

- YES NO Penicillin
- YES NO Sulfa
- YES NO Shellfish
- YES NO Are you allergic to any other medicine? Please list the medicine and the reaction it caused:

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CURRENT MEDICATION

- YES NO Are you currently taking any medication?

List all of your current prescription and non-prescription medicines and dosages. Refer to the labels for accuracy. Include any pills, liquids, drops, ointments, injections, powders, or other medicines. (for example, aspirin, eye drops, Coumadin, birth control pills, etc.)

Name, Strength *(mg,etc.)*, **How often**

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If neccessary, use the back of this form to list additional medical problems, surgeries, or medications.