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
_____	_____	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

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: _____