Medical History Questionnaire

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

Today's date: _____

Name: _____

Your age: _____ Date of Birth: _____

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: _____