

# 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

## 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: \_\_\_\_\_