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
[ ] Blurred reading vision
[ ] Blurred reading vision
[ ] Constant double vision
[ ] Flashing lights or floaters
[ ] Red eyes
[ ] Glare, halos around lights
[ ] Itching or burning eyes
[ ] Eye mattering or tearing
[ ] Foreign body sensation
[ ] Eye pain
[ ] Dry eyes

Have you ever had any of these eye problems?

[ ] Cataract
[ ] Glaucoma
[ ] Macular degeneration
[ ] Dry eyes
[ ] Wore eye patch as a child
[ ] Diabetic Retinopathy
[ ] Other: _____
[ ] Serious eye injury
[ ] Iritis/uveitis
[ ] Lazy eye
[ ] Myopia (Near sighted)
[ ] Retinal detachment
[ ] Hyperopia (Far sighted)

Please list any *eye* surgeries you have had:

[ ] None
[ ] Cataract surgery
[ ] Corneal Transplant
[ ] LASIK
[ ] RK
[ ] PRK
[ ] Foreign body removal
[ ] Vitrectomy
[ ] Retinal laser surgery
[ ] Blepharoplasty surgery
[ ] Trabucelectomy (glaucoma)
[ ] Strabismus surgery (eye muscle)
[ ] Punctal plugs

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

Have you ever had any of these conditions?

[ ] None [ ] Dizziness [ ] High blood pressure
[ ] Stroke [ ] Allergies [ ] Heart disease
[ ] Arthritis [ ] AIDS, HIV [ ] Lung disease
[ ] Diabetes [ ] Anemia [ ] Thyroid disease
[ ] Cancer [ ] Other: _____
[ ] Headaches _____

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 have any allergies to any medications?

[ ] None known [ ] Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Have members of your family had any eye disease?
(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: _____

What non-surgery illness have caused a hospital stay?

_____

_____

_____

Please list any *other* surgeries you have had:

[ ] None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____

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

Do you use:

Tobacco [ ] No [ ] Yes How much: _____

Alcohol [ ] No [ ] Yes How much: _____

If yes, how much? _____

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