Medical History Questionnaire

Today's Date: _____

Last Name _____ First Name _____ MI _____

Please answer the following questions about your current eye problems and medical history:

1. What problems are you **CURRENTLY** having with your eyes ? Which Eye ? When did the problem begin ?

☐ blurred vision ☐ sensitivity to light Right _____
☐ distortion/waviness ☐ poor depth perception
☐ loss of side vision ☐ trouble with colors Left _____
☐ floaters/spots ☐ discomfort
☐ flashing lights ☐ loss of central vision ☐ other _____

2. Have you had any eye problems in the past (e.g., cataract, glaucoma, retina problems, eye surgery, eye injury, etc.) ?
☐ Yes ☐ No If Yes, please explain: _____
_____

3. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, heart disease, asthma, etc.) ? ☐ Yes ☐ No If Yes, please explain: _____
_____

4. Current medications, including eye drops: _____
_____

5. Do you have any allergies to medications ? _____

6. Have you had any of the following problems ? If yes, please explain:

–Chronic fever, unexpected weight loss/gain, fatigue ? ☐yes ☐no _____

–Ear/nose/throat problems (hearing loss, sinus problem) ? ☐yes ☐no _____

–Respiratory problems (shortness of breath, wheezing, asthma, bronchitis) ? ☐yes ☐no _____

–Gastrointestinal problems (heartburn, abdominal pain, diarrhea) ? ☐yes ☐no _____

–Urinary problems (pain or discomfort, bladder infections) ? ☐yes ☐no _____

–Skin disease (rashes, eczema, dermatitis) ? ☐yes ☐no _____

–Musculoskeletal problems (muscle aches, arthritis, swollen joints) ? ☐yes ☐no _____

–Neurologic problems (numbness, weakness, paralysis, headaches) ? ☐yes ☐no _____

–Psychiatric problems (depression, anxiety) ? ☐yes ☐no _____

7. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration) ? ☐ Yes ☐ No If Yes, please explain: _____

8. Do you smoke tobacco ? ☐ Yes ☐ No Drink alcohol ? ☐ Yes ☐ No

_____ Reviewed by physician Comments: _____