

NAME _____

DATE _____

MEDICAL QUESTIONNAIRE \ EYE HISTORY

What ocular problem brings you here? _____

YES NO

Do you wear glasses for vision ? _____

Do you wear contact lenses ? _____

Last time changed ? _____

Do you have glaucoma ? _____

If yes how is it being treated ? _____

Have you had cataract surgery ? _____

Which eye right _____ Date of Surgery _____ Surgeon: _____

left _____ Date of Surgery _____ Surgeon: _____

Do you have any other eye surgery or eye diseases ? Yes _____ No _____

Right eye _____ Date _____ Surgeon: _____

Left eye _____ Date _____ Surgeon: _____

Last eye exam _____ Eye Doctor: _____

MEDICAL - SOCIAL HISTORY

Medical doctor's name _____ Address _____

Where you born prematurely ? Yes _____ No _____

Have you ever suffered from any of the following ?

YES NO

YES NO

Aids or other infectious disease _____ Hepatitis or other liver disease _____

Heart condition _____ Bleeding disorder or anemia _____

High blood pressure _____ Ulcer or other digestive disease _____

Stroke or Neurological disease _____ Thyroid or gland disease _____

Cancer _____ Circulatory problems _____

Lung Disease _____ Do you smoke ? _____

Diabetes _____ Do you consume beer, wine, or liquor ? _____

If yes, how long ? _____ Date of last blood sugar _____ Result _____

List **ALL** medications presently taking, please include eye drops

List any medication allergies _____

Other surgery or illness, or hospitalization not noted above ? _____

FAMILY HISTORY

Is there any family history of: YES NO

Cataracts _____ Relative _____

Glaucoma _____ Relative _____

Retinal Disease _____ Relative _____

Diabetes _____ Relative _____

Hypertension _____ Relative _____

Other eye or systemic disease _____ Relative _____

Anemia _____ Relative _____