ADULT MEDICAL HISTORY QUESTIONNAIRE – OPHTHALMOLOGY

Name:_____ Date of Birth:____/____/_____

Pharmacy:_____ Location:_____

Please tell us why you are here today: _____

_____

Current Symptoms:

- Flashes
- Floaters
- Distortion
- Blurred Vision
- Visual Field Defect
- Blank Spots
- Watery Eyes/Tearing
- Pain or Irritation
- Light Sensitivity
- Discharge
- Double Vision
- Foreign Body Sensation
- Other_____

PLEASE MARK ALL THAT APPLY. THINGS YOU ARE BEING TREATED FOR, OR HISTORY OF.

Past Ocular History:

- Overall Healthy
- Amblyopia (Lazy Eye)
- Astigmatism
- Cataracts
- Diabetic Retinopathy
- Dry Eyes
- Glasses/Contact lenses
- Glaucoma
- Hyperopia (far sighted)
- Iritis
- Keratoconus
- Macular Degeneration
- Misaligned eyes (Strabismus)
- Myopia (Near sighted)
- Optic Neuritis
- Ret. Detachment/Tear
- Eye Trauma
- Prosthetic
- Other:_____

Ocular Surgeries:

- No prior ocular surgery
- Facial Cosmetic Surgery
- Cataract Surgery
- Corneal Transplant
- Retinal Laser Surgery
- LASIK
- LASEK
- Radial Keratotomy
- Punctal Plugs
- Strabismus Surgery (eye muscle surgery)
- Trabeculectomy (glaucoma surgery)
- Vitrectomy
- Scleral Buckle
- Enucleation
- Other:_____

Family History:

- Blindness
- Cancer
- Cataracts
- Diabetes
- Glaucoma
- Retinal Detachment
- Macular Degeneration
- Kidney Disease
- High Blood Pressure
- Migraine
- Heart Disease
- Stroke
- Thyroid Disease
- Other:_____

Review of Systems: (Please mark all that apply)

Integumentary (Skin)
- Skin Cancer
- Eczema
- Psoriasis
- Rosacea
- Other:_____

Respiratory
- Asthma
- Bronchitis
- Emphysema
- COPD
- Lung Cancer
- Tuberculosis (TB)
- Other:_____

Cardiovascular
- High Blood Pressure
- High Cholesterol
- Atherosclerosis
- Heart Disease
- Arrhythmia
- Pacemaker
- Heart Attack
- Other:_____

Gastrointestinal
- Colon Cancer
- Liver Cancer
- Constipation
- Ulcers
- Reflux/Heartburn

Genitourinary
- Kidney Disease
- Prostate Cancer
- Ovarian/Uterine CA
- Other:_____

Musculoskeletal
- Rheumatoid Arthritis
- Arthritis
- Fibro/Polymyalgia
- Sarcoidosis
- Osteoporosis
- Gout
- Other:_____

Neurological
- Bell's Palsy
- Dementia
- Brain Tumor
- Parkinson's Disease
- Migraines/Headaches
- Myasthenia Gravis
- Multiple Sclerosis
- Meningitis
- Seizures
- Stroke (CVA)
- Dizziness
- Hearing Loss

Endocrine
- Type I Diabetes
- (Juvenile) Type II Diabetes
- Diabetic Suspect
- Hypothyroidism
- Hyperthyroidism
- Graves' Disease
- Pituitary Tumor
- Other:_____

Hematologic/Lymphatic
- AIDS/HIV
- Anemia
- Bleeding Disorder
- Breast Cancer
- Hepatitis A/B/C
- Leukemia
- Lupus
- Lyme Disease
- Lymphatic Cancer
- Herpes Simplex
- Herpes Zoster
- Histoplasmosis
- Shingles
- Syphilis
- Toxoplasmosis
- Other:_____

Psychiatric
- Anxiety
- Depression
- Bipolar Disorder
- PTSD
- Schizophrenia
- Other:_____

Other Medical Diseases: _____
_____
_____

General Surgeries / Operations: (Please list) _____
_____ _____
_____ _____
_____ _____
_____

Medication Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Any Sensitivity to: (please circle)
BETADINE / IODINE / ADHESIVE TAPE / ERYTHROMYCIN

Current Medications / Eye Drops / Vitamins / Minerals:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Social History: (Please circle all that apply)

Alcohol use: YES / NO / FORMER How Often _____ times per _____
Tobacco Use: YES / NO / FORMER How Often _____ times per _____
Drug Use: CURRENT / PAST / NEVER
Occupation:_____
Frequency of Work: FULL TIME / PART TIME / RETIRED
Student: YES / NO
Pregnant / Nursing YES / NO Delivery Date:_____
Living Situation: ALONE / WITH FAMILY / CARE FACILITY

Signature:_____Date:_____

Thank you for taking the time to fill out this form.