

Medical History Questionnaire
(Please print clearly. Use the back if you need more space.)

Today's date _____

Name _____

Your age _____ Your race _____

Who is your usual medical doctor? _____

What is the main reason for coming here? _____

Do you have any of these eye symptoms?

- Blurred distance vision Glare, halos around lights
- Blurred reading vision Itching/Burning of eyes
- Double vision Eye mattering or tearing
- Wear contact lenses Dry eyes Eye pain
- Flashing lights, Floaters Red eyes None

Do you have allergies to latex or medications?

- None Latex Yes, to: _____

What eye medications do you currently use?

- None Artificial tears

What other medications do you currently use?

- None Aspirin Antihistamines

Others (list dose and frequency) _____

Have you had any of these eye problems? None

- Cataract Eye injury
- Glaucoma Iritis
- Macular degeneration Lazy eye
- Retinal detachment Wore patch as child

Other _____

What eye surgeries have you had? None

Cataract operation: Which eye? When?: _____

Laser treatment: Which eye? When?: _____

Glaucoma surgery: Which eye? When?: _____

Eye muscle surgery: Which eye? When?: _____

Eyelid or other surgery: Which eye? When?: _____

Has anyone in your family had eye diseases?

- Cataract Macular degeneration Crossed eyes
- Glaucoma Retinal detachment None

Other _____

Do you currently have any of the following conditions?

- Headaches Allergies High blood pressure
- Dizziness Diabetes Heart disease
- Stroke Cancer Thyroid disease
- Arthritis AIDS, HIV Lung disease
- Pregnant Other _____

Do you use? Tobacco Alcohol

What non-surgery illnesses have cause a hospital stay?

What non-eye surgeries have you had?
