Medical History Questionnaire - Envision Eye Specialists

(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 symptoms?

☐ Blurred distance vision ☐ Glare, halos around lights
☐ Blurred reading vision ☐ Itching or burning eyes
☐ Constant double vision ☐ Eye mattering or tearing
☐ Flashing lights or floaters ☐ Foreign body sensation
☐ Red Eyes ☐ Dry Eye ☐ Eye Pain

Do you have any allergies to any medications?

☐ None known ☐ Yes, which ones? (list below)

Medication Name	What reaction did you have?

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
		1 2 3 4 at bedtime

Which *other* medications do you currenly take?

☐ None ☐ Aspirin on a daily basis

Medication Name	Amount	How many times/day
		1 2 3 4 at bedtime
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Have you ever had any of these eye problems?

☐ Cataract ☐ Serious eye injury
☐ Glaucoma ☐ Iritis/uveitis
☐ Macular degeneration ☐ Lazy eye
☐ Wore eye patch as a child ☐ Retinal detachment
☐ Other: _____

Have you ever had any of these conditions?

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

_____

Have members of your family had any eye diseases? (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 _____

Please list any *eye* surgeries you have had:

Type of Eye Surgery	Which Eye		Year
	Right	Left	
	Right	Left	
	Right	Left	
	Right	Left	

Please list any *other* surgeries you have had:

☐ None

Type of Surgery	Year

What non-surgery illness have casue a hospital stay?

_____

_____

_____

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 use? ☐ Tobacco ☐ Alcohol

Would you like to wear contact lenses?

☐ Yes ☐ Not interested at this time

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