**Medical History Questionnaire**

*Please print clearly and use the back if you need more space. Check all that apply.*

Name _____

Date_____ Date of Birth_____

Who is your medical doctor? _____

Approximate date of your last dilated eye exam:

_____

What is the main reason for your visit today?

_____

Do you currently wear contacts, or previously? Yes No

Have you ever had any of these eye problems?

___ Cataracts ___ Glaucoma ___ Dry Eyes

___ Macular Degeneration ___ Retinal Detachment

___ Serious Eye Injury ___ Lazy Eye ___ Iritis/ Uveitis

Other: _____

Have any members of your family had eye conditions?

___ Cataracts ___ Glaucoma ___ Dry Eyes

___ Macular Degeneration ___ Retinal Detachment

___ Serious Eye Injury ___ Lazy Eye ___ Iritis/ Uveitis

Other: _____

Have you ever had any of these conditions?

___ High Blood Pressure ___ Heart Problems

___Arthritis ___ Lung Problems ___ Stroke

___ Ulcers ___ Cancer ___ High Cholesterol

___ Thyroid Disease ___ Diabetes

___ Hep B ___ Hep C ___ HIV Other _____

*(Only applies to diabetic patients)*

Blood sugar _____ A1c _____Type 1 ___ Type 2

Do you take insulin? Yes No

*(Only applies to glaucoma patients)*

What year were you diagnosed with glaucoma? _____

Name of previous ophthalmologist? _____

Month and year of your last visual field test? _____

Have you received the flu vaccine? Yes No

Have you received the pneumonia vaccine? Yes No

Has any of your <u>family</u> ever had any of these conditions?

___ High Blood Pressure ___ Heart Problems

___Arthritis ___ Lung Problems ___ Stroke

___ Ulcers ___ Cancer ___ High Cholesterol

___ Thyroid Disease ___ Diabetes

Other: _____

Height? _____ Weight? _____

Do you currently smoke? Yes No

If not, are you a former smoker? Yes No

Do you drink alcohol? Yes No

If yes, frequency? _____

Have you previously taken Flomax/ tamsulosin? Yes No

What eye medications are you currently taking?

___ None ___ Artificial Tears

| Eye Medication name: | Amount | How many times/day | | | | |
|---|---|---|---|---|---|---|
| _____ | _____ | 1 | 2 | 3 | 4 | 5+ |
| _____ | _____ | 1 | 2 | 3 | 4 | 5+ |
| _____ | _____ | 1 | 2 | 3 | 4 | 5+ |

What other medications are you currently taking?

_____

_____

Please list eye any surgeries/ procedures you have had below

| Type of Eye Surgery | Year | Which Eye | |
|---|---|---|---|
| _____ | _____ | Right | Left |
| _____ | _____ | Right | Left |
| _____ | _____ | Right | Left |

Please list any surgeries/ procedures you have had below

_____

_____

_____

Please list all medication allergies you may have

_____

_____

_____

What non-surgery illnesses have caused a hospital stay?

_____

_____

_____

*If more space is needed you may use the back.*