Retina & Glaucoma associates

Medical History Questionnaire

Patient Name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Date of Last Physical Exam: _____ Date of Last Eye Exam: _____

Review of Systems

What kind of eye problems are you having? Please note which eye and how long.

Eye Pain _____

Loss of Vision _____

Distorted Vision _____

Loss of Side Vision _____

Flashing Lights _____

Floaters _____

Trauma to Eyes _____

Other Symptoms _____

Do you have any of these **symptoms**? Please **CIRCLE** all that apply.

Fever --- Chills --- Weight Changes --- Fatigue --- Chest Pains --- Angina --- Irregular Heart Beat

Cough --- Shortness of Breath --- Heart Burn --- Nausea --- Vomiting --- Constipation --- Diarrhea

Blood in Stool --- Frequent Urination --- Blood in Urine --- Muscle Pain --- Joint Pain/Stiffness

Skin Problems --- Numbness --- Tingling --- Seizures --- Loss of Consciousness --- Headaches

Heat or Cold Intolerance --- Excessive Thirst --- Bleed or Bruise Easily --- Rashes

Do you have any of these **diseases?** Please **CIRCLE** all that apply.

High Blood Pressure --- Heart Attack --- Stroke --- Diabetes --- Thyroid Disease --- Anemia

Psychiatric Disease --- Bowel Disease --- Connective Tissue Disease --- Epilepsy --- Asthma

Lung Disease --- Kidney Disease --- Other _____

Please list all **allergies** to medications. _____

_____

_____

_____

Have you ever been diagnosed with **cancer**? Please describe. _____

_____

_____

_____

Please list all **major injuries**. _____

_____

_____

Please list all **eye surgeries**. _____

_____

_____

_____

Please list all **other surgeries**. _____

_____

_____

_____

Please list all **medications**. _____

_____

_____

_____

_____

_____

Past Ocular History

Have you ever had (check all that apply):

_____ Crossed Eyes

_____ Lazy Eye

_____ Retinal Detachment

_____ Cataract

_____ Diabetic Retinopathy

_____ Macular Degeneration

_____ Retinal Tear

_____ Glaucoma

Family History

Do you have a family history of (check all that apply):

_____ Cataract

_____ Glaucoma

_____ Macular Degeneration

_____ Retinal Detachment

_____ Diabetes

_____ Heart Disease

_____ High Blood Pressure

_____ Inherited Eye Disease

Social History

Marital Status (please circle one): Married ----- Divorced ----- Single ----- Widowed

Is someone available to help you when you are ill (Medicare requirement/)? Yes ----- No

Current or past occupation: _____

Do you drive? Yes No Any problems? _____

Do you drink alcohol? Yes No How many drinks per week? _____

Do you smoke/chew tobacco? Yes No Packs/day _____ Years _____

Have you used illegal drugs? Yes No

Signature: _____ Date: _____