Medical Questionnaire

Do you wear glasses? Yes or No

Do you wear contact lenses? Yes or No

Have you had any previous eye problems, eye surgeries, or eye trauma? If yes please explain:

____
____
____
____

Do you take any eye drops? Yes or No

Medication	Which Eye (R, L, Both)	How many times a day?
__________	__________	___________
__________	__________	___________
__________	__________	___________

Do you take any other medications? (Please list the name only).

____
____
____
____

Do you have any allergies to medications? Yes or No

Name of Medication	Type of Reaction
_________________	______________
_________________	______________
_________________	______________
_________________	______________
_________________	______________

Past Medical History

If you are women, is there any chance that you might be pregnant? Yes or No

Do you have any of the following conditions? (Check those that apply.) ☐ None

- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Migraine Headaches
- ☐ Large amount of blood loss
- ☐ Irregular Heartbeat
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Seasonal Allergies
- ☐ Anemia
- ☐ Eczema
- ☐ Anxiety
- ☐ Arthritis
- ☐ Enlarged prostate
- ☐ Blood clots
- ☐ Cancer: _____________
- ☐ Stroke
- ☐ Poor breathing
- ☐ HIV of AIDS
- ☐ Crohn's disease
- ☐ Depression
- ☐ Gallbladder disease
- ☐ Heartburn/ reflux
- ☐ Hepatitis
- ☐ Irritable bowel disease
- ☐ Liver disease
- ☐ Chest pain
- ☐ Osteoporosis
- ☐ Stomach ulcers
- ☐ Kidney disease
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Other: _____________

Family History

Does anyone in your family have the following: ☐ **NONE**

- ☐ Glaucoma Relation: ___________
- ☐ Macular Degeneration Relation: ___________
- ☐ Retinal Detachment Relation: ___________
- ☐ Other Eye Disorder Relation: ___________

Do you smoke? Yes No Formerly
If yes, how many times a day? ______________
How many years? ______________

Do you drink alcohol? Yes No Formerly
If yes, how often? ______________

What is your profession? ______________
Do you live alone? Yes No

Review of Systems

Have you recently experienced any of these symptoms? (Check those that apply.) ☐ **NONE**

General
- ☐ Fatigue
- ☐ Fevers
- ☐ Weight gain/loss

Ear/Nose/Throat
- ☐ Hearing loss
- ☐ Cold or flu-like symptoms
- ☐ Sinus problems

Breathing
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Heart
- ☐ Chest pain or pressure
- ☐ Palpitation (feeling of an irregular heart beat)
- ☐ Leg swelling

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation

Genital/Urinary
- ☐ Pain with urination
- ☐ Blood in the urine
- ☐ Genital sores

Skin
- ☐ Rashes

Hormonal
- ☐ Excessive thirst
- ☐ Feeling cold or hot
- ☐ Bulging eyes

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness of extremities

Psychological
- ☐ Emotional problems
- ☐ Psychological problems

Musculoskeletal
- ☐ Arthritis
- ☐ Joint swelling
- ☐ Weakness

Blood
- ☐ Easy bruising/bleeding