Medical History Questionnaire
Southtowns Eye Center

Name: ____

Do you have any **allergies** to medication?

☐ no known drug allergies ☐ Yes (list below)

Name	What type of reaction did you have?
____________	________________________
____________	________________________
____________	________________________
____________	________________________
____________	________________________

Which **eye medications** do you currently take?

☐ None ☐ Artificial tears

Medication Name	Which Eye	How many times per day?
_______________	______	
_______________	______	
_______________	______	
_______________	______	
_______________	______	

Current Medications ☐None

Medication Name	Dose	How many times per day?
_______________	_______	
_______________	_______	
_______________	_______	1 2 3 4 at bedtime
_______________	_______	
_______________	_______	
_______________	_______	
_______________	_______	
_______________	_______	
_______________	_______	
_______________	_______	

Do you smoke? ☐ yes ☐ no

Previous smoker? ☐ yes quit? _______ ☐ no

Do you use alcohol? ☐ yes ☐ no

C**ontact lenses**? ☐ yes ☐ no

If yes, how many **hours/day** do you wear them? ______

Have you ever had any of these **eye problems**?

☐ Cataract ☐ Glaucoma

☐ Iritis ☐ Retinal Detachment

☐ Floaters ☐ Macular Degeneration

☐ Eye turn in / out ☐ Poor vision even with glasses

☐ Eye injury___________________________________

Other: ____

If you have **glaucoma**:

In what year was the diagnosis first made? ___________

Month and year of your last visual field: _____________

Previous Eye Doctor: ____________________________

Todays Date: _______________

Please list any **eye surgeries** you have had?

☐ None

Type of Surgery	Eye	Month/Year
__________________	_____	________
__________________	_____	________
__________________	_____	________
__________________	_____	________
__________________	_____	________

Has your mother, father, sister, brother, grandparents, aunts or uncles had any of the diseases listed below? Type which of them has on the line.

☐ Glaucoma_______________________________

☐ Cataracts_______________________________

☐ Macular Degeneration______________________

☐ Iritis___________________________________

☐ Eye turn in / out __________________________

☐ Floaters_________________________________

☐ Poor vision even with glasses________________

☐ Retinal detachment________________________

☐ Laser for: ______________________________

☐ Eye surgery: ____________________________

Have you ever had any of these conditions:

☐ None ☐ Irregular heart beat

☐ Anemia ☐ Kidney problems

☐ Anxiety ☐ Lupus

☐ Arthritis ☐ Migraines

☐ Crohn's ☐ MS

☐ Depression ☐ Parkinson's

☐ Diabetes ☐ Psoriasis

☐ Emphysema ☐ Rheumatoid arthritis

☐ GERD ☐ Rosacea

☐ Headaches ☐ Seasonal allergies

☐ Hearing loss ☐ Seizures

☐ Heart disease ☐ Sinusitis

☐ High cholesterol ☐ Stroke

☐ Hypertension ☐ Thyroid disease

☐ Cancer: ________________________________

☐ Other: _________________________________

List any **other surgeries** that you have had:

☐ None

Type of Surgery	Month/Year
___________________________	________
___________________________	________
___________________________	________
___________________________	________
___________________________	________