

Medical History Questionnaire

Southtowns Eye Center

Name: _____

Today's Date: _____

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

no known drug allergies Yes (list below)

Name	What type of reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

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

None Artificial tears

Medication Name	Which Eye	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: _____

Current Medications

Medication Name	Amount	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

None

1 2 3 4 at bedtime

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: _____

Do you smoke? yes no
 Previous smoker? yes quit? _____ no
 Do you use alcohol? yes no

Contact 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: _____

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

Type of Surgery	Month/Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have **glaucoma**:
 In what year was the diagnosis first made? _____
 Month and year of your last visual field: _____
 Previous Eye Doctor: _____