# Medical History Questionnaire

(Please check boxes)

**Today's date**_____

**Name:** _____**age:**_____

**Medical Doctor Name**_____
**Endocrinologist Name**_____

***MAIN REASON FOR VISIT TODAY*:**

_____
_____
_____

***Do you have any of these eye symptoms?***

❑ Blurred vision ❑Glare
❑ Difficulty reading ❑ Itching
❑ tearing ❑ Discharge
❑ Flashes/floaters ❑ Foreign body sensation
❑ Red Eyes ❑ Double vision
❑ Eye Pain ❑ Other:_____

***Do you wear GLASSES?*** ❑ Yes ❑ No
*If yes? (Check all that apply):* ❑*Reading* ❑ *Distance*
❑*Progressives* ❑*Bifocals* ❑*Computer*

***Do you wear CONTACT LENSES?*** ❑ Yes ❑ Not
*If yes? Brand* _____

***PAST HISTORY OF EYE DISEASES:*** ❑ **None**

❑ Cataract ❑ Glaucoma
❑ Macular degeneration ❑ Lazy eye
❑ Retinal detachment
Other: _____

***PAST EYE SURGERIES:*** ❑ **None**

| Type of Eye Surgery | Which eye? | Year |
|---|---|---|
| | | |
| | | |

***FAMILY HISTORY OF EYE DISEASE:*** ❑ **None**

❑ Glaucoma ❑ Cataract ❑ Strabismus ❑Blindness
❑ Macular degeneration ❑ Retinal detachment
❑ Other: _____

***EYE MEDICATIONS:*** ❑ **None**

| Name of medication | How many times/day |
|---|---|
| ❑Tears | |
| | |
| | |
| | |

***ALLERGIES TO MEDICATIONS OR OTHER:***

❑ **None known** ❑ Yes (list below)

Medication Name What reaction did you have?

_____
_____

***SYSTEMIC MEDICATIONS:*** ❑ **None**

| MEDICATION | DOSE | TIMES/DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PROSTATE MEDS?**❑Flomax (tamsulosin) ❑Hytrin
❑Cardura ❑Rapaflo ❑Uroxatrol

***MEDICAL CONDITIONS:*** ❑ **None**

| | | |
|---|---|---|
| ❑ Diabetes | ❑ Headaches | ❑ High blood pressure |
| ❑ Arthritis | ❑ Dizziness | ❑ Heart disease |
| ❑ Stroke | ❑ Allergies | ❑ Lung disease |
| ❑ Cancer | ❑ AIDS, HIV | ❑ Thyroid disease |
| ❑ Stents | ❑ Anemia | ❑ Arrhythmia |
| ❑ Other: | | ❑ Blood disorder |

***LIST PAST SURGERIES*:** ❑ **None**

Type of Surgery Year

_____ _____
_____ _____
_____ _____

***HOSPITALIZATIONS:*** ❑ **None**

_____
_____
_____

***Smoking?*** ❑ yes ❑ no ❑ former
***Alcohol use?*** ❑ yes ❑ no ❑ social
***Pregnant?*** ❑ yes ❑ no

***Do you have problems with any of these systems at this time? (please check box)***

❑ Gastrointestinal ❑ Ear/Nose/Throat
❑ Cardiovascular ❑Genitourinary
❑ Musculoskeletal ❑Mental
❑ Endocrine ❑Blood/Lymph
❑ Nervous system ❑Respiratory
❑ Allergic/immune ❑Headaches
❑ skin disorder
❑other_____

***PATIENT SIGNATURE:***_____