MEDICAL HISTORY QUESTIONNAIRE

What is the reason for today's eye exam?

_____

Do/Did you have? (Answer yes or No)

Cataracts_____, Glaucoma_____, Retinal Disease_____, Diabetes_____,
Heart Disease_____, High blood Pressure_____, Lung Disease_____,
Ear/Nose/Throat Disease_____, Psychiatric Disorder_____
Stroke_____, HIV (AIDS) or Autoimmune Disease_____,
Hepatitis_____ , Tuberculosis_____, Skin Problems_____, Neurological
Disease_____ Cancer_____, Thyroid Disease_____, Jaundice_____,
Liver Problem_____ Chronic Back Problem_____, Kidney Disease_____
Dialysis _____, Anxiety Problem_____, Rosacea _____,
Multiple Sclerosis_____, Sjogrens Syndrome_____,
Prostrate Problem_____

Did you have any kind of Surgery? & When?

_____
_____
_____

Do You Use ?

Contact Lens_____, Eye drops for Allergy_____/Glaucoma_____/Dry eyes_____

List of Current Medication:

_____
_____
_____
_____
_____
_____

Do you have any of the following symptoms?

Dry Eyes_____, Blurry Vision_____, Redness_____, Burning_____,
Itching_____, Light sensitivity_____, Tearing/Watering_____, Eye Fatigue_____
Foreign Body sensation_____, Contact Lens Discomfort_____,
Scratchy feeling or grit in the eye_____

Allergies(yes or No)

Penicillin_____, Sea Food_____, Latex_____, Local/General Anesthesia_____
Any Other Drug_____, Other_____

Signature: _____, **Date:**_____