Medical History Questionnaire - Eye Associates Group, LLC

Name ______________________________ **Date** ______________

Please list current problems with eye health and vision.

Please circle those that apply to your eyes:

Burning	Light Sensitivity	Tearing or watering	Blurred or Reduced Vision
Itching	Pain	Discharge	Foreign Body Sensation
Irritation	Headaches	Floaters or Flashes	Double Vision

List problems with your eyewear.

Family Doctor ______________________ **Last Eye Doctor** ______________________

Other eye specialists currently treating you: ______________________

Review of Systems:

Please circle those items that apply to you:

Current Constitutional: Fever Weight Loss Headache Pains Dizziness Inflammation Fatigue Joint Pain Shortness of Breath

Ears, Nose & Throat: Hearing Loss Sore Throat Cough Dry Mouth Earache Sinus Infections Pain in Jaw or Temple Pain on Chewing

Cardiovascular: Heart Attack Bypass Angina High Blood Pressure High Cholesterol Congestive Heart Failure Arrhythmia Pacemaker Coronary Artery Disease Valve Disease

Respiratory: Emphysema Asthma COPD Lung Cancer Tuberculosis Bronchitis Pneumonia

Gastrointestinal: Stomach Cancer Ulcers GERD Reflux Colon Cancer Crohn's Disease

Genitourinary: Kidney Disease Dialysis Bladder Infections Prostate Problems or Cancer Ovarian Cancer Pregnancy

Musculoskeletal: Arthritis Rheumatoid Arthritis Spinal Disorders Osteoporosis

Integumentary: Breast Cancer Skin Cancer Melanoma Psoriasis Skin Infections

Neurological: Stroke Mini Stroke Brain Injury Seizures Migraines Tremors MS Parkinsonism Alzheimer's Brain Tumor Aneurysm

Psychiatric /Emotional: ADHD Bipolar Depression Schizophrenia Anxiety Dementia Insomnia

Endocrine: Diabetes Growth Problems Thyroid Pituitary Tumor

Blood /Lympathatic: Bleeding Disorder Anemia Leukemia Lymphoma

Allergies/Immune: Seasonal Allergy Medication Allergies Food Allergies Lupus

Please List Any Other Serious Illnesses, Not Listed Above:

List Medications You Are Allergic to:

Circle Those That Apply to You:

Tobacco None Per Day 1/ Pack or less More than 1 Pack/day

Alcohol None Social Moderate Heavy

Ocular History:

Circle Those That Apply to You Personally:

Glaucoma
Cataract
Macular Degeneration
Other Eye Disease
Retinal Disease
Blindness
Crossed Eyes
Lazy Eyes
Histoplamosis
Diabetes
Cancer
Heart Disease
High Blood Pressure

Family History:

Circle Those That Apply to Your Family.
(Blood Relationships Only)

Please Indicate the Relationship to You (i.e. Mother, Father, Sister, etc)

Glaucoma ______________
Cataract ______________
Macular Degeneration ______________
Other Eye Disease ______________
Retinal Disease ______________
Blindness ______________
Crossed Eyes ______________
Lazy Eyes ______________

Diabetes ______________
Cancer ______________
Heart Disease ______________
High Blood Pressure ______________

Eye Medications:

List any eye medications (drops, ointments and/or vitamins). Please include tears and other over-the-counter drops.

[ ] No Eye Medications

Systemic Medications:

Please list all other general medications and vitamins you are taking. Indicate the reason for the medication when possible. You may attach a list of your medications if you have one.

[ ] No Systemic Medications

Medication	**Condition**	**Medication**	**Condition**

Use this space to discuss any other problems or additional medications.

Eye Surgeries:

Please list any eye surgeries, lasers or eye injection treatments you may have had.

[ ] No Eye Surgeries

Date	Which Eye	Type of Surgery	Surgeon

General Surgeries:

Please list all other general surgeries you have had.

[ ] No General Surgeries

Date	Type of Surgery	Surgeon

Use this space to discuss any problems or complications from any Ocular Surgeries you have had.