The Glaucoma CENTER, PC

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **DOB:** _____

Pharmacy: _____

Location: _____

Are you allergic to any medications? ☐ No ☐ Yes **Sulfa** **Penicillin**

List others: _____

PAST EYE HISTORY

Do you currently take any eye drops? ☐ No ☐ Yes **Please list eye drops below :**

Name of Drop	Dosage	How taken

Do you have any allergies to eye drops? ☐ Yes ☐ No List: _____
History of cataract, glaucoma ☐ Yes ☐ No _____
History of crossed/lazy eye ☐ Yes ☐ No _____
Eye injury or other trauma ☐ Yes ☐ No _____
Eye disease(s) ☐ Yes ☐ No _____
Eye surgery ☐ Yes ☐ No _____
Do you wear contact lenses? ☐ Yes ☐ No Type: Soft Hard Gas Permeable

List major illnesses:

☐ Heart disease
☐ Anemia
☐ Thyroid disease
☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Cold hands/feet
☐ Arthritis
☐ Depression
☐ Blood transfusion
☐ Tuberculosis
☐ Epilepsy/Seizures
☐ Headaches/migraines
☐ Cancer/type: _____
☐ Breathing problems/Asthma
☐ Previous head trauma
☐ Excessive weight loss/gain
☐ Kidney problems/stones
☐ HIV/AIDS
☐ Hepatitis A B C

Other: _____

List any major surgical procedures:

_____

_____

_____

Medical History Questionnaire Page 2

PAST MEDICAL HISTORY

Please list all medications that you are currently using:

Name of Medication	Dosage	How taken

Have you received any vaccinations this year: ☐ **Pneumonia** ☐ **Influenza** ☐ **other:**_____

FAMILY HISTORY

OCULAR	YES	NO	RELATIONSHIP
Blindness	☐	☐	
Cataract(s)	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retina detachment	☐	☐	
MEDICAL			
Diabetes	☐	☐	
Other (list)	☐	☐	

SOCIAL HISTORY

Do you drink alcohol? ☐ ☐ **How much?**_____

Smoking status ☐ Current smoker How much per day?_____ ☐ Former Smoker ☐ Never smoked

Do you now or have you ever used illegal drugs? ☐ **YES** ☐ **NO List:**_____

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If YES, give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss or blurred vision	☐	☐	
Itching, burning, or discharge	☐	☐	
Redness	☐	☐	
Gritty feeling/dryness/tearing	☐	☐	
Glare/light sensitivity, or halos	☐	☐	
Infection of lids or styes	☐	☐	

Are any of the following activities difficult for you?

Driving ☐ **Night vision** ☐ **Reading** ☐ **Daily activities** ☐

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**