**Glaucoma-Cataract Consultants, Inc.**
**Medical History Questionnaire**

Name: ______________________________ Date of Birth: _________________ Account #: ___________________

Today's Date: _________________________ Age: __________

***Ocular/Medical History***

List **all** medications you are currently taking including oral contraceptives, aspirin, over the counter medications, and home remedies.

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

List any allergies: ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

List all major **surgeries** and/or **hospitalizations** you have had: ______________________________
______________________________________________________________________________
______________________________________________________________________________

Last Eye Exam: ________________________
Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? _____________________
Do you wear contact lenses? □No □Yes If yes, what type? □ RGP □ Soft

Are you currently experiencing any of the following problems with your eyes? **Check the box if "*yes*."**

| | | |
|---|---|---|
| □ Blurred Vision | □ Halos | □ Redness |
| □ Loss of Vision | □ Glare / Light Sensitivity | □ Excess Tearing / Watering |
| □ Loss of Side Vision | □ Dryness | □ Eye Pain or Soreness |
| □ Distorted Vision | □ Sandy or Gritty Feeling | □ Mucous Discharge |
| □ Double Vision | □ Foreign Body Sensation | □ Chronic Infection of the Eye or Eyelid |
| □ Tired Eyes | □ Burning | |
| □ Flashes / Floaters in Vision | □ Itching | □ Styes or Chalazion |

Have you been diagnosed with any of the following ocular problems? **Check the box if "*yes*."**

| | | |
|---|---|---|
| □ Cataracts | □ Glaucoma | □ Retinal Detachment |
| □ Crossed Eyes | □ Lazy Eye | □ Drooping Eyelid |
| □ Eye Injury | □ Macular Degeneration | □ Other: ______________________ |

***Family History*** Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| | **Relation to You** | | **Relation to You** |
|---|---|---|---|
| □ Blindness | ____________ | □ Cancer | ____________ |
| □ Cataract | ____________ | □ Diabetes | ____________ |
| □ Crossed Eyes | ____________ | □ Heart Disease | ____________ |
| □ Glaucoma | ____________ | □ High Blood Pressure | ____________ |
| □ Macular Degeneration | ____________ | □ Kidney Disease | ____________ |
| □ Retinal Detachment | ____________ | □ Lupus | ____________ |
| □ Arthritis | ____________ | □ Thyroid Disease | ____________ |

***Review of Systems*** Please check the box beside any problem you currently have, or have ever had, in the following areas:

ALLERGIC/IMMUNOLOGIC ◻ All Normal
- ◻ Allergy / Hayfever

CARDIOVASCULAR / CARDIAC ◻ All Normal
- ◻ Arteriosclerosis
- ◻ Heart Disease
- ◻ High Blood Pressure
- ◻ High Cholesterol

CONSTITUTIONAL ◻ All Normal
- ◻ Fever
- ◻ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ◻ ALL Normal
- ◻ Sinus Congestion
- ◻ Dry Throat / Mouth

ENDOCRINE ◻ All Normal
- ◻ Diabetes
- ◻ Thyroid Disease
- ◻ Chronic Fatigue

GASTROINTESTINAL ◻ All Normal
- ◻ Diarrhea
- ◻ Constipation
- ◻ Ulcers
- ◻ Reflux

GENITOURINARY ◻ All Normal
- ◻ Kidney Disease
- ◻ Ovarian / Uterine Cancer
- ◻ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ◻ All Normal
- ◻ Anemia
- ◻ Bleeding Problems
- ◻ Breast Cancer

INTEGUMENTARY (Skin) ◻ All Normal
- ◻ Skin Cancer
- ◻ Rashes
- ◻ Easy Bruising

MUSCULOSKELETAL ◻ All Normal
- ◻ Rheumatoid Arthritis
- ◻ Muscle Pain
- ◻ Joint Pain

NEUROLOGICAL ◻ All Normal
- ◻ Headaches
- ◻ Dizziness
- ◻ Seizures
- ◻ Stroke

PSYCHIATRIC ◻ All Normal
- ◻ Anxiety
- ◻ Depression
- ◻ Memory Loss
- ◻ Hallucinations

RESPIRATORY ◻ All Normal
- ◻ Asthma
- ◻ Bronchitis
- ◻ Emphysema
- ◻ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: ____________________

____________________________________________

____________________________________________

____________________________________________

Are you pregnant or nursing? ◻ No ◻ Yes

***Social History*** This information is kept strictly confidential. However, **you may discuss this portion directly with your doctor if you prefer.**

Please check the following box if you wish to discuss your *Social History* directly with your doctor: ◻

Do you drive? ◻ No ◻ Yes If yes, describe any visual difficulty while driving: ____________________

Do you use tobacco products? ◻ No ◻ Yes If yes type/amount/how long? ____________________

Do you drink alcohol? ◻ No ◻ Yes If yes, type/amount/how long? ____________________

Do you use illegal drugs? ◻ No ◻ Yes If yes, type/amount/how long? ____________________

Indicate by checking the box if you have been infected with or exposed to: ◻ Gonorrhea ◻ Hepatitis ◻ HIV ◻ Syphillis

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________