NISWANDER EYE CENTER – MEDICAL HISTORY QUESTIONNAIRE

NAME_____DATE OF BIRTH_____DATE_____
WHAT IS THE REASON FOR YOUR VISIT TODAY? _____
_____

PLEASE CIRCLE YES OR NO AND ENTER DATE

OCULAR HISTORY

AGE RELATED MACULAR DEGENERATION YES NO DATE D IAGNOSED_____
AMBLYOPIA (LAZY EYE) YES NO DATE DIAGNOSED_____
CATARACTS YES NO DATE DIAGNOSED_____
GLAUCOMA YES NO DATE DIAGNOSED_____
OTHER_____

OCULAR SURGERY

CATARACT SURGERY RIGHT EYE LEFT EYE DATE(S)_____
COSMETIC EYELID SURGERY RIGHT EYE LEFT EYE DATE(S)_____
GLAUCOMA SURGERY OR LASER RIGHT EYE LEFT EYE DATE(S)_____
RETINAL SURGERY OR LASER RIGHT EYE LEFT EYE DATE(S)_____
OTHER EYE OPERATIONS _____
HAVE YOU EVER HAD AN EYE TRAUMA OR INJURY? RIGHT EYE LEFT EYE DATE(S)_____
PLEASE EXPLAIN_____

FAMILY OCULAR HISTORY

AGE RELATED MACULAR DEGENERATION YES NO RELATIONSHIP_____
AMBLYOPIA (LAZY EYE) YES NO RELATIONSHIP_____
CATARACTS YES NO RELATIONSHIP_____
GLAUCOMA YES NO RELATIONSHIP_____
HIGH MYOPIA 9NEARS YES NO RELATIONSHIP_____
RETINAL PROBLEMS YES NO RELATIONSHIP_____

DO YOU WEAR CONTACT LENSES? YES NO SOFT LENSES GAS PERMEABLE LENSES
HOW MANY HOURS PER DAY DO YOU WEAR YOUR LENSES? _____
HOW MANY DAYS A WEEK DO YOU WEAR YOUR LENSES? _____

MEDICAL HISTORY

ALZHEIMER'S YES NO DATE DIAGNOSED_____
ARTHRITIS YES NO DATE DIAGNOSED_____
ASTHMA YES NO DATE DIAGNOSED_____
CANCER YES NO DATE DIAGNOSED_____
HIGH CHOLESTEROL YES NO DATE DIAGNOSED_____
DIABETES YES NO DATE DIAGNOSED_____
HIGH BLOOD PRESSURE YES NO DATE DIAGNOSED_____
HEART DISEASE YES NO DATE DIAGNOSED_____
HIV (+) YES NO DATE DIAGNOSED_____
MIGRAINE YES NO DATE DIAGNOSED_____
MULTIPLE SCLEROSIS YES NO DATE DIAGNOSED_____
THYROID YES NO DATE DIAGNOSED_____
STROKE YES NO DATE DIAGNOSED_____
PSYCHIATRIC YES NO DATE DIAGNOSED_____

HAVE YOU EVER EXPERIENCED A SERIOUS INJURY IN A CAR ACCIDENT?
YES NO DATE(S)_____
PLEASE EXPLAIN_____

HAVE YOU EVER HAD A HEAD TRAUMA? YES NO DATE_____
PLEASE EXPLAIN_____

PLEASE TURN PAPER OVER AND COMPLETE THE BACK SIDE.

SURGICAL HISTORY

ANGIOPLASTY YES NO EXPLAIN_____DATE_____
BACK SURGERY YES NO EXPLAIN_____DATE_____
BLOOD TRANSFUSION YES NO EXPLAIN_____DATE_____
DIALYSIS YES NO EXPLAIN_____DATE_____
GASTRIC BYPASS YES NO EXPLAIN_____DATE_____
HEART SURGERY/BYPASS YES NO EXPLAIN_____DATE_____
INSULIN PUMP YES NO EXPLAIN_____DATE_____
MASTECTOMY YES NO EXPLAIN_____DATE_____
PROSTATE YES NO EXPLAIN_____DATE_____
RADIATION YES NO EXPLAIN_____DATE_____
OTHER _____

SOCIAL HISTORY

DO YOU DRIVE? YES NO DAYTIME ONLY_____
DO YOU SMOKE? YES NO HOW MANY PER DAY_____
DO YOU DRINK ALCOHOL? YES NO HOW OFTEN_____
DO YOU USE DRUGS? YES NO

FAMILY MEDICAL HISTORY

ALZHEIMER'S YES NO RELATIONSHIP_____
ASTHMA YES NO RELATIONSHIP_____
CANCER YES NO RELATIONSHIP_____
DIABETES YES NO RELATIONSHIP_____
HEART DISEASE YES NO RELATIONSHIP_____
HIGH BLOOD PRESSURE YES NO RELATIONSHIP_____
STROKE YES NO RELATIONSHIP_____
THYROID YES NO RELATIONSHIP_____
OTHER_____

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING **MEDICATIONS**:

PLAQUENIL (hydroxychloroquine) or chloroquine	YES	NO			
FLOMAX (tamulosin)	YES	NO	**TAMOXIFEN**	YES	NO
TOPAMAX (topiramate)	YES	NO	**ETHAMBUTOL**	YES	NO
VIAGARA, CIALIS, LEVITRA	YES	NO	**ACCUTANE (isoretinoid)**	YES	NO
CORDARONE (amiodarone)	YES	NO	**PREDNISONE**	YES	NO

PLEASE LIST ANY OTHER **MEDICATIONS AND EYEDROPS** CURRENTLY USED:

DRUG NAME	DOSAGE	# TIMES USED PER DAY

ALLERGIES:

PENICILLIN YES NO REACTION_____
SULFA YES NO REACTION_____
LATEX YES NO REACTION_____
IODINE YES NO REACTION_____
ANY OTHER ALLERGIES_____
_____