

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:

<u>DRUG NAME</u>	<u>DOSAGE</u>	<u># TIMES USED PER DAY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES:

PENICILLIN	YES	NO	REACTION _____
SULFA	YES	NO	REACTION _____
LATEX	YES	NO	REACTION _____
BETADINE	YES	NO	REACTION _____
ANY OTHER ALLERGIES _____			

FAMILY HISTORY: (MOTHER, FATHER, GRANDPARENTS, SIBLINGS)

<p>HAS ANY MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING: <u>Please circle all that apply:</u> RETINAL PROBLEMS, BLINDNESS, GLAUCOMA, CROSS OR LAZY EYE, CATARACT, DIABETES, CANCER, HEART DISEASE, THYROID PROBLEM, HIGH BLOOD PRESSURE, STROKE OTHER MEDICAL PROBLEMS _____</p>
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SOCIAL HISTORY:

<p>CURRENT OCCUPATION _____ DO YOU DRIVE? YES NO DO YOU DRINK ALCOHOL? YES NO How much? _____ DO YOU SMOKE? YES NO How much? _____ How may years? _____ HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO</p>

FOR STAFF USE ONLY. MEDICAL HISTORY REVIEWED BY:

INITIALS _____ DATE _____ INITIALS _____ DATE _____
 INITIALS _____ DATE _____ INITIALS _____ DATE _____ 08/09

NISWANDER EYE CENTER – MEDICAL HISTORY QUESTIONNAIRE

NAME _____ DATE OF BIRTH _____ DATE _____
WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

WHEN WAS YOUR LAST EYE EXAM? _____

DO YOU WEAR GLASSES? YES NO CONTACT LENSES? YES NO

PLEASE DESCRIBE ANY CURRENT EYE PROBLEMS. PLEASE CIRCLE YES OR NO

EXPLANATION:

SUDDEN LOSS OF VISION	YES	NO	_____
BLURRED VISION	YES	NO	_____
LOSS OF SIDE VISION	YES	NO	_____
DOUBLE VISION	YES	NO	_____
FLOATERS (SPOTS)	YES	NO	_____
FLASHES OF LIGHT	YES	NO	_____
REDNESS	YES	NO	_____
SANDY OR GRITTY FEELING	YES	NO	_____
ITCHING/BURNING	YES	NO	_____
EXCESS TEARING/WATERING	YES	NO	_____
LIGHT SENSITIVITY	YES	NO	_____
EYE PAIN OR SORENESS	YES	NO	_____
INFECTION OF EYE OR LID	YES	NO	_____
TIRED EYES	YES	NO	_____
CROSSED EYES, LAZY EYE	YES	NO	_____
DROOPING EYELID	YES	NO	_____
OTHER EYE PROBLEMS	YES	NO	_____

MEDICAL HISTORY: PLEASE CIRCLE YES OR NO

EXPLANATION:

CATARACT	YES	NO	_____
CATARACT SURGERY	YES	NO	_____
OTHER EYE SURGERY	YES	NO	_____
GLAUCOMA	YES	NO	_____
CROSSED OR TURNED EYE	YES	NO	_____
RETINAL PROBLEMS	YES	NO	_____
MIGRAINE HEADACHES	YES	NO	_____
DIABETES	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____
DIFFICULTY BREATHING	YES	NO	_____
ASTHMA/HAYFEVER	YES	NO	_____
HEART DISEASE	YES	NO	_____
HIGH CHOLESTEROL	YES	NO	_____
THYROID PROBLEMS	YES	NO	_____
OTHER MEDICAL PROBLEMS	YES	NO	_____
HEART SURGERY	YES	NO	_____
OTHER SURGERY	YES	NO	_____

PLEASE TURN PAPER OVER AND COMPLETE THE BACK SIDE.