Medical History Form

Current Eye or Eye related problems or complaints (check all that apply)

☐Cataract ☐Decreased Vision ☐Discharge ☐Glare

☐Itching/Burning ☐Redness ☐Dryness ☐Halos

☐Other or explain any concerns:_____

_____

_____

Past Eye Surgery **Date** **Explanation** **N/A**

☐ **Check here if No Past Eye Surgeries**

☐Cataract Surgery _____ ☐

☐Glaucoma Surgery _____☐

☐LASIK/PRK/RK_____☐

☐Other Eye Surgery _____☐

Prior Eye Problems (please mark all that apply)

☐ Check here if No Past Eye Problems/History

☐ Astigmatism
☐ Presbyopia (needing bifocals)
☐ Color Blindness
☐ Double Vision (Diplopia)
☐ Eye or Eyelid Cancer
☐ Facial Rosacea
☐ Eye Shingles (Varicella Zoster Ophthalmicus)
☐ Severe Eye Injury (Ruptured Globe)
☐ Farsightedness
☐ Tearing/Watering Constantly (Epiphora)
☐ Pupil Problems (Horner's Syndrome or Tonic Pupil)
☐ Cataract
☐ Cloudiness After Cataract Surgery (Posterior Opacification)
☐ Dislocated Lens (Ectopia Lentis)
☐ Retinal Detachment
☐ Retinal Tear without Detachment
☐ Diabetic Retinopathy
☐ Epiretinal Membrane (ERM)
☐ Floaters (Posterior Vitreous Detachment-PVD)
☐ High Eye Pressure (Ocular Hypertension)
☐ Idiopathic Intracranial Hypertension
☐ Sudden or Intermittent Loss of Vision
☐ Blocked Retinal Artery (CRAO, BRAO, Giant Cell Arteritis)
☐ Nearsightedness
☐ Lazy Eye (Amblyopia)
☐ Crossed or Turned Eyes (Strabismus)
☐ Droopy Eyelid (Ptosis)
☐ Eye Allergies (Allergic Conjunctivitis)
☐ Eye Herpes (HSV Keratitis)
☐ Keratoconus
☐ Eye Bone Fracture (Orbital Fracture)
☐ Cornea Infection (Ulcer)
☐ Dry Eye Syndrome
☐ Iritis/Uveitis
☐ Optic Neuropathy (NAION)
☐ Myasthenia Gravis
☐ Intraocular Foreign Body
☐ Blind Eye
☐ Macular Degeneration
☐ Blocked Retinal Vein (CRVO, BRVO)
☐ Retinal Swelling (Cystoid Macular Edema)
☐ Glaucoma
☐ Optic Neuritis (from Multiple Sclerosis)
☐ Thyroid Eye Disease (Graves' Disease)
☐ Pituitary Tumor (Pituitary Adenoma)

Medical History (please provide explanation of any checked in the space below)

☐ **Check here if No Past Medical Problems/History**

☐ Anesthetic Complications ☐ Bleeding Disorder ☐ Brain Tumor ☐ Cancer
☐ Diabetes ☐ Emphysema (COPD) ☐ Sleep Apnea (or machine) ☐ Asthma ☐ Pneumonia in last month
☐ Oxygen Requirement at Home ☐ Heart Attack ☐ Congestive Heart Failure (CHF)
☐ High Blood Pressure ☐ Irregular Heart Rhythm ☐ Heart Stents in last 6 months
☐ Heart Valve Disease ☐ Stroke ☐ Pacemaker/Defibrillator Implant
☐ Rheumatoid Arthritis ☐ Migraine ☐ AIDS/HIV
☐ Thyroid Disorder ☐ Hepatitis ☐ Dementia

Explanation_____

_____

_____

Date of last Routine Eye Exam:_____ Eye Doctor/Clinic:_____

Date of last Medical Exam:_____ Primary Care Physician/Clinic:_____

Do you wear glasses? Never / All of the time / Sometimes / Work ONLY / Reading ONLY / Driving ONLY

How old are your present glasses:_____ Do you wear prescription sunglasses? YES or NO

Do you wear contacts? YES or NO Brand:_____

Do you use contact solution if so what brand?_____

Wearing Schedule: DAILY / OVERNIGHT / Replacement Schedule: DAILY / BIWEEKLY / MONTHLY / YEARLY

Medication name and reason taken How much? (Dosage) How do you take it? How often? (Frequency)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____