

Medical History Questionnaire – Ophthalmology

Please fax completed form to (610) 874-0318

Name _____ Date of Birth ____/____/____ Ethnicity _____

Primary Care Physician _____ Referring Doctor _____ Referring Optometrist _____

Pharmacy _____ Location _____ Pharmacy Phone _____

Please tell us what brings you in to see us today: _____

Are you interested in our other services? LASIK or Custom Cataract Surgery

Past Medical History: (Please check all that apply)

- | | | | |
|-----------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> None |
| <input type="checkbox"/> Atrial fibrillation
(irregular heartbeat) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bone marrow transplant | <input type="checkbox"/> End stage renal disease | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung cancer | _____ |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Lymphoma | |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate cancer | |
| | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation treatment | |

Past Surgical History: (Please check all that apply)

- | | |
|-------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Appendix removed (Appendectomy) | <input type="checkbox"/> Liver transplant |
| <input type="checkbox"/> Bladder removed (Cystectomy) | <input type="checkbox"/> Liver shunt |
| <input type="checkbox"/> Breast biopsy (Right Left Bilateral) | <input type="checkbox"/> Ovaries removed: Endometriosis |
| <input type="checkbox"/> Lumpectomy (Right Left Bilateral) | <input type="checkbox"/> Ovaries removed: Ovarian Cancer |
| <input type="checkbox"/> Mastectomy (Right Left Bilateral) | <input type="checkbox"/> Ovaries removed: Cyst |
| <input type="checkbox"/> Colectomy: Colon cancer | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Pancreas removed |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Prostate biopsy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Prostate removed: Prostate cancer |
| <input type="checkbox"/> Gallbladder removed | <input type="checkbox"/> TURP |
| <input type="checkbox"/> Biological valve replacement | <input type="checkbox"/> Basal cell cancer surgery |
| <input type="checkbox"/> Coronary artery bypass | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Mechanical valve replacement | <input type="checkbox"/> Skin biopsy |
| <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Squamous cell carcinoma surgery |
| <input type="checkbox"/> Joint replacement, hip (Right Left Bilateral) | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Joint replacement, knee (Right Left Bilateral) | <input type="checkbox"/> Testicles removed (Right Left Bilateral) |
| <input type="checkbox"/> Kidney biopsy | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Kidney stone removal | <input type="checkbox"/> Hysterectomy: Uterine cancer, Cervical cancer |
| <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> None |
| <input type="checkbox"/> Kidney removal (Nephrectomy) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Liver hepatectomy | |

Please Initial: _____

Please continue on the back side of this page →

Patient Name _____ Date of Birth ____/____/____

Ocular History: *(Please check all that apply)*

- Allergic conjunctivitis
- Blepharitis
- Cataract (Left Eye, Right Eye)
- Contact lenses
- Corneal dystrophy (Left Eye, Right Eye)
- Diabetic retinopathy, background (Left eye, Right Eye)
- Diabetic retinopathy, proliferative (Left eye, Right Eye)
- Dry eyes
- Glaucoma (Left eye, Right Eye)
- Macular degeneration (Left eye, Right Eye)
- Macular ERM "pucker" (Left eye, Right Eye)
- Narrow angles (Left eye, Right Eye)
- Ocular hypertension (Left eye, Right Eye)
- Ophthalmic migraine
- Pseudoexfoliation
- Retinal tear (Left eye, Right eye)
- Strabismus
- Vitreous floaters (Left eye, Right eye)
- None**
- Other:** _____

Ocular Surgery: *(Please check all that apply)*

- Blepharoplasty (Left eye, Right eye)
- Cataract surgery (Left eye, Right eye)
- Corneal transplant (Left Eye, Right Eye)
- Eye muscle surgery (Left eye, Right Eye)
- Intravitreal injections (Left eye, Right Eye)
- LASIK (Left eye, Right Eye)
- Laser peripheral iridotomy, LPI (narrow angles) (Left eye, Right Eye)
- Laser trabeculoplasty- ALT, SLT, LTP (Left eye, Right Eye)
- Photorefractive keratectomy (PRK) / Refractive surgery (Left eye, Right Eye)
- Punctal plugs (Left eye, Right eye)
- Retinal laser (Left eye, Right eye)
- Trabeculectomy (Left eye, Right eye)
- Tube shunt (Left eye, Right eye)
- YAG capsulotomy (Left eye, Right eye)
- None**
- Other:** _____

Medications/Eye Drops/Vitamins: *Please list all current medications including strength and dosage if known.*

Allergies: *Please list all allergies and describe your reaction or mark if NO KNOWN ALLERGIES*

Family History: *Please indicate on line whether this pertains to mother (M), father (F), sister (S), brother (B), grandmother (GM), and/or grandfather (GF).*

- | | | |
|---------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Migraine _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Retinal detachment _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> High blood pressure _____
(hypertension) | <input type="checkbox"/> Strabismus (lazy eye) _____ |
| <input type="checkbox"/> Stroke (CVA) _____ | <input type="checkbox"/> Macular degeneration _____ | <input type="checkbox"/> None |
| <input type="checkbox"/> Diabetes _____ | | |

Social History: *Please mark all that apply.*

- Never Smoked
- Quit: (date) _____
- Smokes less than daily
- Smokes daily (# packs) _____

Please Initial: _____