WILLIAMS AND WITHERELL
Customized Cataract Surgery

OPHTHALMIC SURGICAL ASSOCIATES, INC.
610-874-5261 I eyesbyosa.com

Medical History Questionnaire – Opthalmology

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)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation *(irregular heartbeat)*
- ☐ Bone marrow transplant
- ☐ High Blood Pressure
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage renal disease
- ☐ GERD
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other: __________ ________________ ________________

Past Surgical History: *(Please check all that apply)*

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

*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.*

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

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

- ☐ Blindness ______________
- ☐ Cancer ________________
- ☐ Cataracts ______________
- ☐ Stroke (CVA) ___________
- ☐ Diabetes _______________
- ☐ Glaucoma ___________________
- ☐ Heart disease ________________
- ☐ High blood pressure (hypertension) ___________
- ☐ Macular degeneration __________
- ☐ Migraine______________________
- ☐ Retinal detachment ______________
- ☐ Strabismus (lazy eye) ____________
- ☐ **None**

Social History: *Please mark all that apply.*

☐ Never Smoked ☐ Quit: (date)_______ ☐ Smokes less than daily ☐ Smokes daily (# packs)______

*Please Initial:*__________