

MEDICAL HISTORY QUESTIONNAIRE – OPHTHALMOLOGY

STERLING EYE CENTER, P.L.L.C. ~ DANIEL H. SHARP, M.D.
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Today's Date: ___/___/___

Name: _____ Date of Birth: ___/___/___

Pharmacy: _____ Family Doctor: _____

Please tell us why you are here today: _____

Current Symptoms:

- | | | |
|--|--|---|
| <input type="checkbox"/> Flashes | <input type="checkbox"/> Blank Spots | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Watery Eyes/Tearing | <input type="checkbox"/> Foreign Body Sensation |
| <input type="checkbox"/> Distortion | <input type="checkbox"/> Pain or Irritation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Light Sensitivity | |
| <input type="checkbox"/> Visual Field Defect | <input type="checkbox"/> Discharge | |

Have you ever had or currently have any of the following: (Please check all that apply)

Past Ocular History:

- | | | |
|---|--|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Glasses/Contact lenses | <input type="checkbox"/> Eye Trauma |
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Hyperopia (far sighted) | <input type="checkbox"/> Prosthetic (Artificial Eye) |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Iritis | <input type="checkbox"/> Retinal Detachment/Tear |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Vitreous Floaters |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other: _____ |

Ocular Surgeries:

- | | | |
|--|--|--|
| <input type="checkbox"/> No prior ocular surgery | <input type="checkbox"/> LASIK | <input type="checkbox"/> Trabeculectomy (glaucoma surgery) |
| <input type="checkbox"/> Facial Cosmetic Surgery | <input type="checkbox"/> LASEK | <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Radial Keratotomy | <input type="checkbox"/> Scleral Buckle |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Enucleation |
| <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Strabismus Surgery (eye muscle surgery) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Retinal Laser Surgery | | |

General Surgeries / Operations: (Please list)

_____	_____
_____	_____
_____	_____
_____	_____

**Medical History: Have you ever had or currently have any of the following:
(Please check all that apply)**

Integumentary (Skin)

- Skin Cancer
- Eczema
- Psoriasis
- Rosacea
- Other: _____

Respiratory

- Asthma
- Bronchitis
- Emphysema
- COPD
- Lung Cancer
- Tuberculosis (TB)
- Other: _____

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Atherosclerosis
- Heart Disease
- Arrhythmia
- Pacemaker
- Heart Attack
- Other: _____

Gastrointestinal

- Colon Cancer
- Liver Cancer
- Constipation
- Ulcers
- Reflux/Heartburn
- Other: _____

Genitourinary

- Kidney Disease
- Prostate Cancer
- Ovarian/Uterine CA
- Other: _____

Musculoskeletal

- Rheumatoid Arthritis
- Arthritis
- Fibro/Polymyalgia
- Sarcoidosis
- Osteoporosis
- Gout
- Other: _____

Neurological

- Bell's Palsy
- Dementia
- Brain Tumor
- Parkinson's Disease
- Migraines/Headaches
- Multiple Sclerosis
- Meningitis
- Seizures
- Stroke (CVA)
- Dizziness
- Hearing Loss
- Other: _____

Endocrine

- Type I Diabetes (Juvenile)
- Type II Diabetes
- Diabetic Suspect

- Hypothyroidism
- Hyperthyroidism
- Graves' Disease
- Pituitary Tumor
- Other: _____

Hematologic/Lymphatic/Other

- AIDS/HIV
- Anemia
- Bleeding Disorder
- Breast Cancer
- Hepatitis A/B/C
- Leukemia
- Lupus
- Lyme Disease
- Lymphoma/Lymphatic Cancer
- Herpes Simplex
- Herpes Zoster / Shingles
- Histoplasmosis
- Syphilis
- Toxoplasmosis
- Other: _____

Psychiatric

- Anxiety
- Depression
- Bipolar Disorder
- PTSD
- Schizophrenia
- Other: _____

Name _____

Current Medications / Eye Drops / Vitamins / Minerals:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies and Intolerances:

Reaction

Severity

_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Any Sensitivity to: (please circle) BETADINE / IODINE / ADHESIVE TAPE / LATEX

Social History: (Please circle all that apply)

Alcohol use: YES / NO / FORMER

How Often _____ times per _____ When quit _____

Tobacco Use: YES / NO / FORMER

How Often _____ times per _____ When quit _____

Drug Use: CURRENT / PAST / NEVER Marijuana: CURRENT / PAST / NEVER

Occupation: _____

Frequency of Work: FULL TIME / PART TIME / RETIRED

Living Situation: ALONE / WITH FAMILY / CARE FACILITY MARRIED / SINGLE

Family History:

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING:

F=Father M=Mother S=Sister B=Brother GM=Grandmother GF=Grandfather P=Paternal M=Maternal

CONDITION:	WHO?	CONDITION	WHO?
Glaucoma		Diabetes	
Retinal Disease		Cancer	
Blindness		Heart Disease	
Macular Degeneration		High Blood Pressure	
Strabismus/Crossed Eye/Lazy Eye		Thyroid	
Cataract		Migraine	

Signature: _____ Date: _____

Thank you for taking the time to fill out this form.