NH EYE ASSOCIATES

MEDICAL & OCULAR HISTORY QUESTIONAIRRE

Name: _____ Date: _____ Age: _____

Preferred Pharmacy Name: _____ Address: _____

Primary Care Doctor Name:_____Referring Doctor Name:_____

1. Please briefly describe the main reason you are being examined today.

2. Do you have any of the following conditions (check all that apply)?

☐ Diabetes	**Type I or Type II: _____**	**Recent Blood Sugar: _____**	**Recent HbA1c: _____**
☐ Cancer (specify):	☐ Sinus Disease	Other:_____	
☐ Anxiety	☐ Arthritis	☐ Asthma	☐ COPD
☐ Cholesterol	☐ Depression	☐ GERD	☐ Hyperthyroid
☐ Hypothyroid	☐ High Blood Pressure	☐ Hearing Loss	☐ Hepatitis
☐ HIV/AIDS	☐ Irregular Heartbeat	☐ Seizure	☐ Stroke
☐ Skin Disorder	☐ Heart Disease	☐ Pregnancy	☐ Dyslexia

3. Please list any surgeries and dates of surgeries:

_____

_____

_____

4. Do you have any of the following eye disorders?

☐ Allergies	☐ Blepharitis	☐ Cataracts	☐ Contact Lens
☐ Corneal Dystrophy	☐ Diabetic Retinopathy	☐ Dry Eye	☐ Glasses
☐ Glaucoma	☐ Macular Degeneration	☐ Macular Pucker	☐ Narrow Angles
☐ Ocular Migraine	☐ Pseudoexfoliation	☐ Retinal Tear	☐ Lazy Eye
☐ Floaters	☐ Other:		

5. Have you had any of the following eye surgeries or procedures?

☐ Cataract Surgery	☐ Corneal Transplant	☐ Eye Muscle Surgery	☐ Injections
☐ LASIK	☐ Laser	☐ Lid Surgery	☐ Glaucoma Surgery
☐ Retina	Other:		

OVER

6. Is there a family history of the following eye diseases? Which family members?

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Blindness
- ☐ Other:
- ☐ Diabetes
- ☐ Retinal Detachment
- ☐ Cataracts

7. Please list all medications, including eye drops (or provide list):

8. Please list any allergies to any medications or substances:

9. How would you describe your smoking history?

- ☐ Current smoker, every day
- ☐ Current smoker, not every day
- ☐ Former smoker
- ☐ Never smoked

10. Do you have any of the following problems?

- ☐ Blurry vision
- ☐ Frequent urination
- ☐ Diabetes
- ☐ Arthritis
- ☐ Dryness, Grittiness or Scratchiness
- ☐ Rash
- ☐ Fever
- ☐ Seizure
- ☐ High Blood Pressure
- ☐ Anxiety
- ☐ Shortness of Breath
- ☐ Anemia
- ☐ Eye Fatigue
- ☐ Soreness or Irritation
- ☐ Burning or Watering
- ☐ Allergies
- ☐ Upset Stomach