NH EYE ASSOCIATES

MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

Preferred Pharmacy Name: _____ Address: _____

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

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

- ☐ Diabetes **Recent Blood Sugar:** _____ **Recent HbA1c:** _____
- ☐ Cancer (specify):
- ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ COPD
- ☐ Cholesterol ☐ Depression ☐ GERD ☐ Hyperthyroid
- ☐ Hypothyroid ☐ High Blood Pressure ☐ Hearing Loss ☐ Hepatitis
- ☐ HIV/AIDS ☐ Irregular Heart Beat ☐ Seizure ☐ Stroke
- ☐ Skin Disorder ☐ Other:

3. Please list any major non-ocular 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
- ☐ Other:

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

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

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

8. Are you allergic to any medications or substances?
   Please list:

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
- ☐ Dry Mouth
- ☐ Rash
- ☐ Fever
- ☐ Seizure
- ☐ High Blood Pressure
- ☐ Anxiety
- ☐ Shortness of Breath
- ☐ Anemia
- ☐ Upset Stomach
- ☐ Allergies

11. Do you have any of the following eye problems?

- ☐ Dryness, Grittiness or Scratchiness
- ☐ Soreness or Irritation
- ☐ Burning or Watering
- ☐ Eye Fatigue