

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.) you have had:

List any surgeries you have had (cataract, tonsillectomy, appendectomy) including date(s):

Have you or your family members ever had any complications from anesthesia? YES NO If yes, explain:

Do you currently have any problems in the following areas? If "YES", please provide information

| | YES | NO | Explanation of Problem |
|---|-----|----|------------------------|
| EYES (Glaucoma, cataract, retinal disease, etc.) | | | |
| Loss of vision | | | |
| Blurred vision | | | |
| Fluctuating vision | | | |
| Distorted vision (halos) | | | |
| Loss of side vision | | | |
| Double vision | | | |
| Dryness | | | |
| Mucous discharge | | | |
| Redness | | | |
| Sandy or gritty feeling | | | |
| Itching | | | |
| Burning | | | |
| Foreign body sensation | | | |
| Excess tearing/watering | | | |
| Glare/light sensitivity | | | |
| Eye pain or soreness | | | |
| Infection of eye or lid (blepharitis, stye) | | | |
| Tired eyes | | | |
| Crossed eyes, lazy eye | | | |
| Drooping eyelid | | | |
| GENERAL/CONSTITUTIONAL | | | |
| Fever | | | |
| Weight loss | | | |
| Other | | | |
| EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.) | | | |
| CARDIOVASCULAR (Heart, vessels, etc.) | | | |
| RESPIRATORY (Asthma, emphysema, etc.) | | | |
| GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.) | | | |
| GENITAL, KIDNEY, BLADDER | | | |
| MUSCLES, BONES, JOINTS (Arthritis, etc.) | | | |
| SKIN (Acne, warts, skin cancer, etc.) | | | |
| NEUROLOGICAL (Multiple sclerosis, etc.) | | | |
| PSYCHIATRIC (anxiety, depression, insomnia) | | | |
| ENDOCRINE (Diabetes, Hypothyroid, etc.) | | | |
| BLOOD/LYMPH (Cholesterolemia, anemia, etc.) | | | |
| ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.) | | | |