CHESTER COUNTY EYE CARE

MB#_____
Date:_____
Reviewed by:_____

MEDICAL HISTORY QUESTIONNAIRE – OPHTHALMOLOGY

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** ☐**Cosmetic Treatments**

Past Medical History: *(Please mark all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ OTHER:_____ _____

Past Surgical History: *(Please mark 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 continue on the back side of this page ⟶

Ocular History: *(Please mark 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 mark 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 Peripherial 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)*

_____

_____

_____

_____

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

_____

_____

_____

_____

Family History - *please indicate on line whether this pertains to mother (M), father (F), siblings (S) and/or grandparents (G):*

- ☐ 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 circle all that apply*

Cigarette Smoking: Never Smoked Quit: (date)_____ Smokes less than daily Smokes daily (# packs)_____

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