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 peripheral 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), sister (S), brother (B), grandmother (GM), and/or grandfather (GF).*

☐ 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 mark all that apply.*

Cigarette Smoking:

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