GOLTSCHMAN STURM EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: **Date of Birth:**

PATIENT MEDICAL HISTORY

***** Many Medical conditions affect the eyes. Please fill out as completely as possible. *****

When was your last physical? _____

Have you used tobacco, cannabis or vaped? ☐ Never ☐ Current user ☐ Former user

Do you currently have or have you been treated for:

Asthma/COPD	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Eczema/Rosacea	☐ Yes	☐ No	Lupus/Sjogren's Syndrome	☐ Yes	☐ No
Elevated Cholesterol	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Diabetes Type 1 or 2	☐ Yes	☐ No	Stroke/TIA	☐ Yes	☐ No
*Since:*_____ *Last A1c=*_____			Thyroid Disease	☐ Yes	☐ No
Stomach/Bowel Disease	☐ Yes	☐ No	Graves' Disease	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Depression	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Psychiatric Disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Alzheimer's/Dementia	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Prostate Issues	☐ Yes	☐ No

Other major medical history: _____

FAMILY HISTORY

Have any blood relatives had any of the following:

Blindness	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Cornea Issues	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Retina Detachment	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			Heart Disease	☐ Yes	☐ No

EYE HEALTH HISTORY

When was your last eye exam: _____

Do you wear any of the following: ☐ Glasses ☐ Contact Lenses ☐ Reading Glasses

Have you been diagnosed with or treated for:

Cataracts	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Diabetic Eye Issues	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No

Any other eye issues: _____

Have you had any of the following surgeries/procedures:

Cataract Surgery	☐ Yes	☐ No	Laser Treatments	☐ Yes	☐ No
Cornea Surgery	☐ Yes	☐ No	Eye Injections	☐ Yes	☐ No
LASIK/PRK	☐ Yes	☐ No	Other: _____		

Are you experiencing any:

Blurry Vision	☐ Yes	☐ No	Dryness	☐ Yes	☐ No
Glare Issues	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Scratchy/Gritty Eyes	☐ Yes	☐ No
Floater/Flashes of light	☐ Yes	☐ No	Tearing/Watery Eyes	☐ Yes	☐ No

****WE WILL NEED A LIST OF YOUR CURRENT MEDICATIONS AND DRUG ALLERGIES ****