



Department of Ophthalmology
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Medical Questionnaire

Patient Name: _____ Date of Birth: _____
Last First Middle initial

Chief medical reason for this visit: _____

Who referred you here? _____
Name Address Tel no

Who is your primary care physician? _____
Name Address Tel no

List any eye conditions you have: _____

List any eye surgeries you have had (including laser procedures): _____

Do you wear contact lenses? _____ Hard Soft Bifocal Toric Brand: _____

* * * * *

General Medical History (check all that apply):

- Asthma
- Pulmonary disease
- Rosacea
- Eczema
- Lupus
- Rheumatoid arthritis
- Osteoarthritis
- Migraine
- Multiple sclerosis
- HIV
- Chronic Hepatitis
- Sickle cell
- Psoriasis
- Cold sores
- Environmental (allergies/ hay fever, etc.)
- Other _____

Please indicate [X] any MEDICAL conditions that you or a blood relative may have or had:

	<i>Self</i>	<i>Mother</i>	<i>Father</i>	<i>Sister(s)</i>	<i>Brother(s)</i>	<i>Maternal Grandmother</i>	<i>Maternal Grandfather</i>	<i>Paternal Grandmother</i>	<i>Paternal Grandfather</i>	<i>Other</i>
Macular Degeneration										
Cataract										
Glaucoma										
Glaucoma Suspect										
Keratoconus										
Retinal Detachment										
Blindness										
Cancer										
Stroke										
Diabetes										
Heart Disease										
High Blood Pressure										
Thyroid Disease										
Other										

Please list current medications with dosage & frequency (including eye medications):

Do you have any allergies to medications? _____

Please list prior surgeries (other than eye)

Date of Surgery

Are you currently experiencing any of the following:

	YES	NO		YES	NO
Constitutional Symptoms Fever, Chills, Weight change, Sleep disturbance			Genitourinary Kidney Stones, Urinary Frequency/ Urgency		
Skin Itching, Dryness, Rashes, Ulcers			Endocrine Hormonal or Thyroidal problems, Cold/Heat Intolerance		
Ear, Nose, Mouth, Throat Deafness, Ear Infections, Vertigo, Mouth Lesions			Musculoskeletal Arthritis, Muscle Pain, Back Problems, Swelling		
Neurological Headache, Seizure, Paralysis, Head Injury, Dizziness			Hematologic/Lymphatic Anemia, Blood Clots, Bleeding Disorders		
Respiratory Shortness of Breath, Chronic Cough, Wheezing			Psychiatric Depression, Anxiety, Psychosis, Mania		
Gastrointestinal Acid Reflux, Constipation, Diarrhea, Vomiting			Cardiovascular Chest Pains, Palpitations		
Do you smoke? If yes, how often? _____			Do you drink? If yes, how often? _____		

"I _____ authorize the use of photography/videography for medical purposes during this visit and consent to the use of this data for the advancement of medical knowledge and/or education, including publications. I understand that while these images may be identifiable, my name and demographic information, as well as protected health information will not be used."

Patient's signature: _____ Date: _____

Reviewed by M.D.: _____ Date: _____

If you are a Pediatric, ROP, or Strabismus Patient PLEASE CONTINUE to page 4 ----->

Pediatric, ROP, or Strabismus Patient Questionnaire

If you have previously been evaluation and treated for this condition, please provide details (including childhood medical and surgical eye treatments):

Name of physician _____ Date _____ Treatment (e.g. glasses, patching, surgery) _____

Please provide information about any other testing that has been done related to this condition (e.g. MRI, spinal tap) or attach records.

Test _____ Date _____ Result _____

For Children under Age 18, please answer the following pertaining to your child’s birth and medical history:

Were there problems during pregnancy (infection, etc.)? _____

Were there problems during delivery (forceps, breech, twins)? _____

Did your child have to stay in the hospital? If so, please describe _____

Has he/she reached normal milestones? If not, please describe. _____

Was he/she born on time? If not, please describe (include weeks premature) _____

What was the child’s weight at birth? _____

Eye exam in the hospital? Yes No If yes, Where? _____ Doctor’s Name _____

Other medical conditions _____

Other surgical procedures _____

Who lives at home with the child? _____

Are there other parents/caregivers involved? If so, please describe: _____

What grade is he/she in? _____

Please indicate [X] if any blood relative may have or had any of the following:

	<i>Self</i>	<i>Mother</i>	<i>Father</i>	<i>Sister(s)</i>	<i>Brother(s)</i>	<i>Other</i>
Strabismus crossed” or “wandering” eyes						
Ambyopia Lazy eye						
Eye Surgery in Childhood						
Glasses before age 6						
Other Genetic Eye Diseases						

ADDITIONAL NOTES: