MEDICAL & OCULAR HISTORY QUESTIONNAIRE

Name: ______________________________________ Date: ______________________ Age: ______

Preferred Pharmacy Name: _______________________ Address: ______________________________

1. Please describe briefly the main reason you are being examined today.

2. Do you have any of the following conditions (check all that apply)?

- ☐ Diabetes **Recent Blood Sugar:** ____________ **Recent HbA1c:** _____________
- ☐ Cancer (specify):

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ COPD
☐ Cholesterol	☐ Depression	☐ GERD	☐ Hyperthyroid
☐ Hypothyroid	☐ High Blood Pressure	☐ Hearing Loss	☐ Hepatitis
☐ HIV/AIDS	☐ Irregular Heart Beat	☐ Seizure	☐ Stroke
☐ Skin Disorder	☐ Other:		

3. Please list any major non-ocular surgeries:

4. Do you have any of the following eye disorders?

☐ Allergies	☐ Blepharitis	☐ Cataracts	☐ Contact Lens
☐ Corneal Dystrophy	☐ Diabetic Retinopathy	☐ Dry Eye	☐ Glasses
☐ Glaucoma	☐ Macular Degeneration	☐ Macular Pucker	☐ Narrow Angles
☐ Ocular Migraine	☐ Pseudoexfoliation	☐ Retinal Tear	☐ Lazy Eye
☐ Floaters	☐ Other:		

5. Have you had any of the following eye surgeries or procedures?

☐ Cataract Surgery	☐ Corneal Transplant	☐ Eye Muscle Surgery	☐ Injections
☐ LASIK	☐ Laser	☐ Lid Surgery	☐ Glaucoma Surgery
☐ Other:			

6. Is there a family history of the following eye diseases?

- [ ] Glaucoma
- [ ] Cataracts
- [ ] Lazy Eye
- [ ] Macular Degeneration
- [ ] Blindness
- [ ] Other:
- [ ] Diabetes
- [ ] Retinal Detachment

7. Please list all medications, including eye drops (or provide list):

8. Are you allergic to any medications or substances?
Please list:

9. How would you describe your smoking history?

- [ ] Current smoker, every day
- [ ] Current smoker, not every day
- [ ] Former smoker
- [ ] Never smoked

10. Do you have any of the following problems?

- [ ] Blurry vision
- [ ] Frequent urination
- [ ] Diabetes
- [ ] Arthritis
- [ ] Dry Mouth
- [ ] Rash
- [ ] Fever
- [ ] Seizure
- [ ] High Blood Pressure
- [ ] Anxiety
- [ ] Shortness of Breath
- [ ] Anemia
- [ ] Upset Stomach
- [ ] Allergies

11. Do you have any of the following eye problems?

- [ ] Dryness, Grittiness or Scratchiness
- [ ] Soreness or Irritation
- [ ] Burning or Watering
- [ ] Eye Fatigue