NEW VISION EYE CENTER MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

Primary Physician (Local Preferred): _____
City State

Primary reason(s) for today's visit:

- ◯ Cataract
- ◯ Glaucoma
- ◯ Dry Eye
- ◯ Diabetes
- ◯ Macular Degeneration
- ◯ Blurred Vision
- ◯ Other: _____

Past Medical History (please check all that apply):

- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ BPH
- ◯ Bone Marrow Transplantation
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Depression
- ◯ Diabetes
- ◯ GERD
- ◯ Hearing Loss
- ◯ Hepatitis
- ◯ Hypertension
- ◯ HIV/AIDS
- ◯ Hypercholesterolemia
- ◯ Hyperthyroidism
- ◯ Hypothyroidism
- ◯ Leukemia
- ◯ Lung Cancer
- ◯ Lymphoma
- ◯ Pacemaker
- ◯ Prostate Cancer
- ◯ Radiation Treatment
- ◯ Seizures
- ◯ Stroke
- ◯ Valve Replacement
- ◯ None
- ◯ Other: _____

Past Surgical History (please check all that apply):

- ◯ Appendix Removed
- ◯ Bladder Removed
- ◯ Mastectomy (R,L,Bilateral)
- ◯ Lumpectomy (R,L,Bilateral)
- ◯ Breast Biopsy (R,L,Bilateral)
- ◯ Breast Reduction
- ◯ Breast Implants
- ◯ Colectomy: Colon Cancer Resection
- ◯ Colectomy: Diverticulitis
- ◯ Colectomy: IBD
- ◯ Gallbladder Removed
- ◯ Coronary Artery Bypass
- ◯ PTCA
- ◯ Mechanical Valve Repplacement
- ◯ Biological Valve Replacement
- ◯ Heart Transplant
- ◯ Kidney Biopsy (R,L)
- ◯ Kidney Removed (R,L)
- ◯ Kidney Stone Removal (R,L)
- ◯ Kidney Transplant
- ◯ Ovaries Removed: Endometriosis
- ◯ Ovaries Removed: Cyst
- ◯ Ovaries Removed: Ovarian Cancer
- ◯ Prostate Removed: Prostate Cancer
- ◯ Prostate Biopsy
- ◯ Skin Biopsy
- ◯ Basal Cell Cancer Surgery
- ◯ Sqamous Cell Carcinoma Surgery
- ◯ Melanoma Surgery
- ◯ Hysterectomy: Fibroids
- ◯ Heart Stint
- ◯ Joint Replacement, Knee (R,L Bilateral)
- ◯ Joint Replacement, Hip (R,L Bilateral)
- ◯ Joint Replacement within the last 2 years
- ◯ None
- ◯ Other: _____

Past Ocular History (please check all that apply):

- ◯ Allergic Conjunctivitis
- ◯ Blepharitis
- ◯ Cataract (R, L)
- ◯ Corneal dystrophy (R, L)
- ◯ Diabetic retinopathy, background (R,L)
- ◯ Dry Eyes
- ◯ Drusen (R, L)
- ◯ Glaucoma (R, L)
- ◯ Macular Degeneration (R, L)
- ◯ Macular Pucker (wrinkle) (R, L)
- ◯ Monovision
- ◯ Narow Angles (R, L)
- ◯ Ocular Hypertension
- ◯ Ophthalmic Migraine
- ◯ Retinal Tear (R, L)
- ◯ Retinal Detachment (R, L)
- ◯ Soft/Hard Contact Lens Wearer
- ◯ Strabismus
- ◯ Lazy Eye/ Amblyopia
- ◯ Floaters (R, L)
- ◯ Other: _____

Past Ocular Surgery (please check all that apply):

- ☐ Blepharoplasty (R, L)
- ☐ Cataract Surgery (R, L)
- ☐ Corneal Transplant (R, L)
- ☐ DSAEK (R,L)
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections (R, L)
- ☐ LASIK (R, L)
- ☐ Monovision (R,L)
- ☐ PRK (R, L)
- ☐ Ptosis Repair
- ☐ Punctal Repair
- ☐ Punctal Plugs (R, L)
- ☐ Strabismus Surgery
- ☐ Retinal Laser (R, L)
- ☐ Trabeculectomy
- ☐ Tube Shunt (R, L)
- ☐ Yag Capsulotomy (R, L)
- ☐ None
- ☐ Other: _____

Family History - Immediate Family Member Only (please check all that apply):

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ CVA/ Stroke
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Macular Degeneration
- ☐ Migraine
- ☐ Retinal Detachment
- ☐ Strabismus
- ☐ None
- ☐ Other: _____

Current Medication List: ☐ None ☐ List Attached

_____ _____

_____ _____

_____ _____

Allergies (Please list any prior drug/substance allergy): ☐ None ☐ List Attached

DRUG/SUBSTANCE NAME — TYPE OF REACTION

_____ _____ ☐ Mild/ ☐ Moderate/ ☐ Severe

_____ _____ ☐ Mild/ ☐ Moderate/ ☐ Severe

_____ _____ ☐ Mild/ ☐ Moderate/ ☐ Severe

EyeDrops (Please list any prior drug/ substance allergy): ☐ None ☐ List Attached

_____ _____

_____ _____

_____ _____

Are you currently experiencing any of the following? (please check all that apply):

- ☐ Poor Vision
- ☐ Eye Pain
- ☐ Tearing
- ☐ Redness
- ☐ Loss of Vision
- ☐ High Blood Pressure
- ☐ Rapid Heart Rate
- ☐ Diabetes
- ☐ Thyroid Abnormalities
- ☐ Chills
- ☐ Ear Ache
- ☐ Dry Mouth
- ☐ Shortness of Breath
- ☐ Upset Stomach
- ☐ Constipation
- ☐ Incontinence
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Headache
- ☐ Depression
- ☐ Weakness
- ☐ Head Injury
- ☐ Decreased Hearing
- ☐ None
- ☐ Other Symptoms: _____

ALERTS: Have you ever or are you currently experiencing any of the following? (Please check all that apply):

- ☐ Allergy to Lidocaine
- ☐ Allergy to Adhesive
- ☐ Artificial Heart Valve
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Flomax
- ☐ MRSA
- ☐ Narrow Angles
- ☐ Pacemaker
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Steroid Responder
- ☐ Other Symptoms: _____

Social History (please check all that apply):

CIGARETTE SMOKING

- ☐ Never Smoked
- ☐ Quit: Former Smoker
- ☐ Smokes Less Than Daily
- ☐ Smokes Daily

ALCOHOL USE

- ☐ None
- ☐ Less than 1 Drink a Day
- ☐ 1-2 Drinks a Day
- ☐ 3 or More Drinks a Day

DRUG USE

- ☐ None

Type of Drug _____ Frequency of Use _____

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