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: _____

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

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
- ◯ Narrow 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: _____

Eye Drops:

◯ None ◯ List Attached

_____ _____

_____ _____

_____ _____

Past Medical History (please check all that apply):

- ○ Alzheimer
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial Fibrillation
- ○ BPH
- ○ Bone Marrow Transplantation
- ○ Breast Cancer
- ○ Colon Cancer
- ○ COPD
- ○ Coronary Artery Disease
- ○ Dementia
- ○ 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 Replacement
- ○ 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
- ○ Squamous Cell Carcinoma Surgery
- ○ Melanoma Surgery
- ○ Hysterectomy: Fibroids
- ○ Heart Stent
- ○ Joint Replacement, Knee (R, L, Bilateral)
- ○ Joint Replacement, Hip (R, L, Bilateral)
- ○ Joint Replacement within last 2 years
- ○ None
- ○ Other: _____

Current Medication List: ○ None ○ List Attached

_____ _____

_____ _____

_____ _____

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: _____

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