NEW VISION EYE CENTER MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

Primary Physician (Local Preferred): _____

City State

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
	Mild / Moderate / Severe
	Mild / Moderate / Severe

Past Ocular Surgery (please check all that apply):

Please identify which eye surgery you have had, if any: (Please check all that apply and give the date and doctor)

- ☐ Cataract surgery (Left Eye): Date_____ Doctor _____
- ☐ Cataract surgery (Right Eye): Date_____ Doctor _____
- ☐ Glaucoma surgery (Left Eye) Date_____ Doctor _____
- ☐ Glaucoma surgery (Right Eye) Date_____ Doctor _____
- ☐ Retinal surgery (Left Eye) Date_____ Doctor _____
- ☐ Retinal surgery (Right Eye) Date_____ Doctor _____
- ☐ Vision correction surgery (Left Eye) Date_____ Doctor _____
- ☐ Vision correction surgery (Right Eye) Date_____ Doctor _____
- ☐ Other (Left Eye) Date_____ Doctor _____
- ☐ Other (Right Eye) Date_____ Doctor _____
- ☐ **Other prior eye conditions or concerns:** _____

Eye Drops:

◯ None ◯ List Attached

Left Eye: _____ Right Eye: _____

Past Medical History (please check all that apply):

- ☐ Alzheimer
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (Type I)
- ☐ Diabetes (Type II)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Pacemaker
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Past Surgical History:

Please specify type of surgeries and dates:

Current Medication List (including dosage):

◯ None ◯ List Attached

Family History (other than yourself):

☐ Unknown Family History

Please circle applicable family members:

☐ Glaucoma	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Macular Degeneration	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Blindness	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Diabetes	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Cancer	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ Heart Disease	Parent	Sibling	Maternal Grandparent	Paternal Grandparent
☐ High Blood Pressure	Parent	Sibling	Maternal Grandparent	Paternal Grandparent

Social History (please check all that apply):

Smoking: ◯ every day smoker ◯ social smoker ◯ former smoker ◯ never smoked

Alcohol Use: ◯ Yes ◯ No If yes, how much and how often? _____

Drug Use: ◯ Yes ◯ No If yes, how much and how often? _____

Other (please check all that apply):

Have you had a flu vaccine? ◯ Yes ◯ No

Have you had a pneumonia vaccine? ◯ Yes ◯ No

Have you had a COVID-19 vaccine? ◯ Yes ◯ No

Have you fallen in the last 2 years? ◯ Yes ◯ No

Are you currently in a wheelchair? ◯ Yes ◯ No

If yes, can you transfer without assistance? ◯ Yes ◯ No

Name: _____ Date of Birth: _____ Today's Date: _____