Eyes of San Antonio

Medical History Questionnaire

RESET FORM

Name_____ Date_____

Date of birth_____ Date of Last Eye Exam_____

List any **medications** you currently take (prescription or over-the-counter):

_____

_____

Do you have **allergies** to any medications □Yes □No Describe_____

List all **major illnesses** (glaucoma, high blood pressure, heart attack, diabetes, etc.) or **injuries**:

_____

_____

List any **surgeries** you have had (cataract, appendectomy, etc.)_____

_____

What is the **main reason** for your visit today?_____

_____

Do you **currently** have any problems in the following areas? If YES, please explain:

EYES (Cataract, retinal disease, glaucoma, etc.)			**Explanation of Problem**
Blurred Vision	□ Yes	□ No	
Loss of Vision	□ Yes	□ No	
Fluctuating Vision	□ Yes	□ No	
Double Vision	□ Yes	□ No	
Turned eye, lazy eye	□ Yes	□ No	
Eye pain or soreness	□ Yes	□ No	
Infection of eye or lid	□ Yes	□ No	
Loss of side vision	□ Yes	□ No	
Distorted vision	□ Yes	□ No	
Dryness	□ Yes	□ No	
Burning	□ Yes	□ No	
Sandy or gritty feeling	□ Yes	□ No	
Foreign body sensation	□ Yes	□ No	
Redness	□ Yes	□ No	
Mucous discharge	□ Yes	□ No	
Itching	□ Yes	□ No	
Excess watering / tearing	□ Yes	□ No	
Glare/Light sensitivity	□ Yes	□ No	
Flashes of light, floaters	□ Yes	□ No	
Tired eyes	□ Yes	□ No	

Do you wear glasses? □ Yes □ No If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? □ Yes □ No Have you ever tried to wear contact lenses □ Yes □ No

Type of contact lenses □ Rigid □ Soft □ Extended wear □ Other Are they comfortable? □ Yes □ No

Are you interested in learning about the advantages of Laser Vision Correction? □ Yes □ No

Do you use a computer on your job? □ Yes □ No # hours daily_____

Do you use a computer at home? □ Yes □ No # hours daily_____

When computing, do your eyes get □ red □ dry □ ache □ sore ?

Do you feel pain or discomfort in your □ neck □ back □ shoulders ?

Do reflections and glare bother you? □ Yes □ No

Past Medical History (check YES only)

___High blood pressure	___History of Eye Injury/Disease	___Ears/Nose/Throat problems
___Diabetes	___Ulcers/Gastritis	___Skin problems
___Thyroid disease	___Arthritis/Joint/Bone problems	___Stroke/Neurological problems
___Asthma/Bronchitis	___Genital/Kidney/Bladder problems	___Sinus problems
___Pregnant and/or Nursing	___Lung/Breathing problems	___Anxiety/Depression
___Headaches/Migraines	___Jaundice/Hepatitis/Liver problems	___Allergic/Sinus/Chronic cough
___Heart disease	___Bleeding disorder	___Fever/Weight Loss or Gain

Name of Family Medical Doctor_____ Dr's Phone_____

Last Medical Exam_____/_____/_____

Family History

Disease			**Relationship to Patient (**M=mother F=father S=sibling GP=grandparent)
Blindness	□ Yes	□ No	_____
Glaucoma	□ Yes	□ No	_____
High Blood Pressure	□ Yes	□ No	_____
Heart Disease	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Kidney Disease	□ Yes	□ No	_____
Macular Degeneration	□ Yes	□ No	_____
Retinal Disease	□ Yes	□ No	_____
Thyroid Disease	□ Yes	□ No	_____
Arthritis	□ Yes	□ No	_____
Cancer	□ Yes	□ No	_____

Confidential Social History

Do you drive a motor vehicle? □ Yes □ No If yes, do you have any difficulty when driving?_____

Do you have any problems with night driving? □ Yes □ No_____

Do you use tobacco products? □ Yes □ No If so, ____packs per day

Do you use recreational drugs? □ Yes □ No If so, how often?_____

Do you consume alcoholic beverages? □ Yes □ No If so, _____ drinks/week

History Reviewed by Doctor_____Date_____