LAKESHORE EYE SPECIALISTS

Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date: _____Pharmacy:_____

Name: _____

Your age: _____ Date of birth: _____

Who is your medical doctor? _____

Who is your optometrist?_____

What is the main reason for your visit today?

_____

Do you have any of these eye symptoms?

❑ Blurred distance vision ❑ Glare, halos around lights
❑ Blurred reading vision ❑ Itching or burning eyes
❑ Constant double vision ❑ Eye mattering or tearing
❑ Flashing lights or floaters ❑ Foreign body sensation
❑ Red Eyes ❑ Dry Eye ❑ Eye Pain

Do you have any allergies to any medications?

❑ None known ❑ Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Which *eye medications* do you currently take?

❑ None ❑ Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which *other* medications do you currently take?

❑ None ❑ Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

❑ Cataract ❑ Serious eye injury
❑ Glaucoma ❑ Iritis/uveitis
❑ Macular degeneration ❑ Lazy eye
❑ Wore eye patch as a child ❑ Retinal detachment
Other: _____

Have you ever had any of these conditions?

❑ None

❑ Stroke ❑ Dizziness ❑ High blood pressure
❑ Arthritis ❑ Allergies ❑ Heart disease
❑ Diabetes ❑ AIDS, HIV ❑ Lung diseases
❑ Cancer ❑ Anemia ❑ Thyroid disease
❑ Kidney disease ❑ Other_____

_____

Have members of your family had any *eye* diseases?

(This would be your father, mother, sister, brother, grandparents)

❑ Glaucoma ❑ Diabetic eye disease or diabetes
❑ Cataract ❑ Crossed eyes ❑ Macular degeneration
❑ Iritis/uveitis ❑ Blindness ❑ Retinal detachment
❑ Poor Vision ❑ Other: _____

Please list any *eye* surgeries you have had:

❑ None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any *other* surgeries you have had:

❑ None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Indicate if you have any of the following symptoms

❑ Fever ❑ Weight loss/gain ❑ Sore throat ❑ coughing
❑ Shortness of breath ❑Chest pain ❑ Irregular heart rate
❑ Abdominal pain ❑ Nausea ❑ Vomiting ❑ Diarrhea
❑ Blood in urine ❑ Painful urination ❑ Frequent urination
❑ Bruising/bleeding ❑ Swollen glands ❑ muscle pain
❑ Joint pain ❑ Numbness ❑ Tingling ❑ Anxiety

Other :_____

Do you use? ❑ Tobacco ❑ Alcohol

Do you wear contact lenses?

❑ Yes ❑ No

What was the approximate date of your last eye examination: _____