Cornea Consultants of Albany, PLLC

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____
Dateof Birth: _____
Date of Visit: _____

Date of Last Eye Exam: _____

List Any Eye Medications/Drops You Currently Use: _____

List Any Other Medications You Currently Take: _____

List Any Allergies to **Medications**: _____

List All Major Illnesses (Glaucoma, Diabetes, High Blood Pressure, etc.) or Injuries (Concussion, etc.): _____

List Any Eye Surgeries You Have Had (Cataract, LASIK, etc.) and Approximate Date: _____

List Any Other Surgeries You Have Had (Tonsillectomy, Appendectomy, etc.): _____

Do you ***currently*** have any problems in the following areas? If **YES**, please explain.	**YES**	**NO**	**DETAILS**
EYE HISTORY			
Loss of vision			
Blurred Vision			
Fluctuating vision			
Double Vision			
Distorted Vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Dryness			
Sandy or gritty feeling			
Redness			
Itching			
Burning			
Excess tearing or watering			
Eye pain or soreness			
Mucous Discharge			
Tired Eyes			

GENERAL HISTORY	YES	NO	DETAILS
General/Constitutional (fever, weight loss, etc)			
Ears, Nose, Throat (sinus, ear infection, etc)			
Cardiovascular (high blood pressure, heart, etc)			
Respiratory (congestion, wheezing, etc)			
Gastrointestinal (stomach upset, diarrhea, etc)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, etc)			
Muscles, Bones, Joints (joint pain, stiffness, etc)			
Skin (acne, warts, growths, rash, etc)			
Neurological (numbness, headache, etc)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc)			
Blood/Lymph (cholesterolemia, anemia, etc)			
Allergic/Immunologic (hay fever, etc)			

FAMILY HISTORY			M=Mother F=Father S=Sibling GP=Grandparent
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Age Related Macular Degeneration			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
Stroke			
High Blood Pressure			
Other			

SOCIAL HISTORY

Current Occupation: _____

Education: _____

Marital Status: _____

Living Arrangements (Nursing Home, Assisted Living, Rehabilitation, etc): _____

Alcohol Consumption: ☐ None ☐ Occasionally ☐ 1/Day ☐ 2-3/Day ☐ 4+/Day

Smoking Habits: ☐ None ☐ Occasionally ☐ 1/2 Pack/Day ☐ 1 Pack/Day ☐ 1+Pack/Day

Do You Drive? ☐ YES ☐ NO

Have You Ever Worn Contact Lenses? ☐ YES ☐ NO

Do You Currently Wear Contact Lenses? ☐ YES ☐ NO If Yes, How Long? _____

Do You Currently Wear Glasses? ☐ YES ☐ NO If Yes, How Long? _____

Patient's Signature: _____ *Date:* _____

Physician's Signature: _____ *Date:* _____