MEDICAL HISTORY QUESTIONNAIRE – OPHTHALMOLOGY

STERLING EYE CENTER, P.L.L.C. ~ DANIEL H. SHARP, M.D.
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970-522-1833

Today's Date:____/____/_____

Name:_____ **Date of Birth**:____/____/_____

Pharmacy:_____ **Family Doctor:** _____

Please tell us why you are here today: _____

_____

Current Symptoms:

- ☐ Flashes
- ☐ Floaters
- ☐ Distortion
- ☐ Blurred Vision
- ☐ Visual Field Defect
- ☐ Blank Spots
- ☐ Watery Eyes/Tearing
- ☐ Pain or Irritation
- ☐ Light Sensitivity
- ☐ Discharge
- ☐ Double Vision
- ☐ Foreign Body Sensation
- ☐ Other_____

Have you ever had or currently have any of the following: (Please check all that apply)

Past Ocular History:

- ☐ **Overall Healthy**
- ☐ Amblyopia (Lazy Eye)
- ☐ Astigmatism
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glasses/Contact lenses
- ☐ Glaucoma
- ☐ Hyperopia (far sighted)
- ☐ Iritis
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Eye Trauma
- ☐ Optic Neuritis
- ☐ Prosthetic (Artificial Eye)
- ☐ Retinal Detachment/Tear
- ☐ Vitreous Floaters
- ☐ Other:_____

Ocular Surgeries:

- ☐ No prior ocular surgery
- ☐ Facial Cosmetic Surgery
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ Foreign Body Removal
- ☐ Retinal Laser Surgery
- ☐ LASIK
- ☐ LASEK
- ☐ Radial Keratotomy
- ☐ Punctal Plugs
- ☐ Strabismus Surgery (eye muscle surgery)
- ☐ Trabeculectomy (glaucoma surgery)
- ☐ Vitrectomy
- ☐ Scleral Buckle
- ☐ Enucleation
- ☐ Other:_____

General Surgeries / Operations: (Please list all surgeries anywhere on your body)

_____ _____

_____ _____

_____ _____

_____ _____

Name_____

Medical History: Have you ever had or currently have any of the following: (Please check all that apply)

Integumentary (Skin)

- ☐ Skin Cancer
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other:_____

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Lung Cancer
- ☐ Tuberculosis (TB)
- ☐ Other:_____

Cardiovascular

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atherosclerosis
- ☐ Heart Disease
- ☐ Arrhythmia
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Other:_____

Gastrointestinal

- ☐ Colon Cancer
- ☐ Liver Cancer
- ☐ Constipation
- ☐ Ulcers
- ☐ Reflux/Heartburn
- ☐ Other:_____

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate Cancer
- ☐ Ovarian/Uterine CA
- ☐ Other:_____

Musculoskeletal

- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Fibro/Polymyalgia
- ☐ Sarcoidosis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other:_____

Neurological

- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Brain Tumor
- ☐ Parkinson's Disease
- ☐ Migraines/Headaches
- ☐ Multiple Sclerosis
- ☐ Meningitis
- ☐ Seizures
- ☐ Stroke (CVA)
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Other:_____

Endocrine

- ☐ Type I Diabetes (Juvenile)
- ☐ Type II Diabetes
- ☐ Diabetic Suspect
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Graves' Disease
- ☐ Pituitary Tumor
- ☐ Other:_____

Hematologic/Lymphatic/Other

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Hepatitis A/B/C
- ☐ Leukemia
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Lymphoma/Lymphatic Cancer
- ☐ Herpes Simplex
- ☐ Herpes Zoster / Shingles
- ☐ Histoplasmosis
- ☐ Syphilis
- ☐ Toxoplasmosis
- ☐ Other:_____

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Other:_____

Name_____

Current Medications / Eye Drops / Vitamins / Minerals:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies and Intolerances:	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Any Sensitivity to:	Reaction
Betadine	_____
Adhesive tape	_____
Iodine	_____
Latex	_____

Alcohol, Tobacco, Drug History: (Please circle all that apply)

Alcohol Use: YES / NO / FORMER

How Often: _____ times per _____ When quit _____

Tobacco Use: YES / NO / FORMER

How Often: _____ times per _____ When quit _____

Drug Use: CURRENT / PAST / NEVER

Marijuana: CURRENT / PAST / NEVER

Family History:

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING:

F=Father M=Mother S=Sister B=Brother GM=Grandmother GF=Grandfather P=Paternal M=Maternal

CONDITION:	WHO?
Glaucoma	
Retinal Disease	
Blindness	
Macular Degeneration	
Strabismus/Crossed Eye/Lazy Eye	
Cataract	

CONDITION	WHO?
Diabetes	
Cancer	
Heart Disease	
High Blood Pressure	
Thyroid	
Migraine	

Signature: _____ Date: _____

Thank you for taking the time to fill out this form.

Name_____

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- ☐ PTSD
- ☐ Schizophrenia
- ☐ Other:_____