Honolulu Eye Clinic

Medical History Questionnaire

Do you have now or have you recently had: (please check YES or NO)

		Dates/Explain:
Fever, chills, night sweats, unexplained fatigue?	☐Y ☐N	
Weight gain or loss over 10 lbs in the last year?	☐Y ☐N	
Loss of vision	☐Y ☐N	
Blurred vision	☐Y ☐N	
Loss of side vision	☐Y ☐N	
Double vision	☐Y ☐N	
Dry eyes	☐Y ☐N	
Eye discharge	☐Y ☐N	
Red eyes	☐Y ☐N	
Sandy or gritty eyes	☐Y ☐N	
Itchy eyes	☐Y ☐N	
Burning eyes	☐Y ☐N	
Eye foreign body sensation	☐Y ☐N	
Eye pain or soreness	☐Y ☐N	
Chronic infection of eyes	☐Y ☐N	
Chronic infection of lids	☐Y ☐N	
Tearing or watering eyes	☐Y ☐N	
Crossed eyes	☐Y ☐N	
Lazy eye	☐Y ☐N	
Droopy eyelid(s)	☐Y ☐N	
Ear, nose, throat problems, loss of hearing, smell?	☐Y ☐N	
Sinus, vertigo, dry mouth, difficulty swallowing?	☐Y ☐N	
Heart / circulation problems?	☐Y ☐N	
Heart attack or angina?	☐Y ☐N	
Congestive heart failure?	☐Y ☐N	
Irregular heart beat?	☐Y ☐N	
Cardiac pacemaker or valve?	☐Y ☐N	
High blood pressure?	☐Y ☐N	
Respiratory problems?	☐Y ☐N	
Asthma; chronic cough?	☐Y ☐N	
Emphysema; bronchitis?	☐Y ☐N	
Tuberculosis or +PPD?	☐Y ☐N	
Gastrointestinal problems?	☐Y ☐N	
Ulcers, diverticulitis, colitis?	☐Y ☐N	
Frequent diarrhea?	☐Y ☐N	
Liver disease, hepatitis?	☐Y ☐N	
Genitourinary disease?	☐Y ☐N	
Kidney, bladder problems?	☐Y ☐N	
Prostate, stones, infections?	☐Y ☐N	
Urinary frequency, STD?	☐Y ☐N	
Muscle weakness, fatigue?	☐Y ☐N	
Arthritis, joint swelling?	☐Y ☐N	
Low back pain, gout?	☐Y ☐N	
Rheumatoid / osteoarthritis?	☐Y ☐N	
Skin, hair, or nail problems?	☐Y ☐N	
Eczema, psoriasis, rosacea?	☐Y ☐N	
Skin cancer, infections?	☐Y ☐N	

		Dates/Explain:
Neurologic disease?	☐Y ☐N	
Stroke, seizures, tremor?	☐Y ☐N	
Parkinson's disease?	☐Y ☐N	
Memory loss, disorientation?	☐Y ☐N	
Anxiety, depression?	☐Y ☐N	
Diabetes, date of onset?	☐Y ☐N	
Thyroid disease?	☐Y ☐N	
Adrenal or pituitary disease?	☐Y ☐N	
Blood disorders, anemia?	☐Y ☐N	
Easy bruising; clotting?	☐Y ☐N	
AIDS or HIV positive?	☐Y ☐N	
Cancer or tumor, type, date?	☐Y ☐N	
Are you pregnant?	☐Y ☐N	
Expected delivery date?		

Family History: Among your **blood relatives**, have they had:

Blindness	☐Y ☐N	
Cataracts	☐Y ☐N	
Glaucoma	☐Y ☐N	
Macular degeneration	☐Y ☐N	
Retinal detachment or disease	☐Y ☐N	
Lazy eye or muscle imbalance	☐Y ☐N	
Cancer or tumor	☐Y ☐N	
Diabetes mellitus	☐Y ☐N	
Heart disease	☐Y ☐N	
High blood pressure	☐Y ☐N	
Bleeding disorder	☐Y ☐N	
Other		

Are you a smoker? ☐Y ☐N How many packs per day?_____

Do you drink alcohol? ☐Y ☐N How many drinks per day?_____

Do you use drugs? ☐Y ☐N

Have you had any **eye surgery, laser**, or injury? ☐Y ☐N

Names & dates of operation(s) or injuries:_____

Eye drops/medications: _____

Prescription & nonprescription medications:_____

Do you have any allergies to medication? ☐Y ☐N

If "Yes", please list:_____

Do you currently wear contact lenses? ☐Y ☐N

If yes, ☐ Soft contacts ☐ Rigid Gas Permeable (RGP)

Do you currently wear glasses? ☐Y ☐N

Details regarding above YES answers:

_____

_____

_____

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_____

Submit