Retina & Vitreous, LLC South Bend, IN 46635

MEDICAL HISTORY QUESTIONAIRE

Name_____**DOB**_____**Date**_____

DO YOU HAVE: **(Circle one)**

Decreased Vision **Distance** Yes No Which eye? _____When did it start?_____

Reading Yes No Which eye? _____When did it start?_____

Side Yes No Which eye? _____When did it start?_____

Double Vision Yes No Which eye? _____When did it start?_____

Spots/Floaters/Veils Yes No Which eye? _____When did it start?_____

Are lines distorted? Yes No Which eye? _____When did it start?_____

EYE HISTORY:

Injury to the eye Was this related to work or auto accident? Yes No Which eye? _____When did it start?_____

Describe injury_____

Glaucoma Yes No Which eye? _____When did it start?_____

Cataract surgery Yes No Which eye? _____When did it start?_____

Other eye surgery/Laser? LASIK? Corneal ? List:_____

What eye medications OR DROPS do you use? List: _____

_____

FAMILY HISTORY: Other than yourself, if any of these diseases are **in your family,** please list the relation to you.

(circle one)

Hypertension Yes No Relation(s)_____

Diabetes Yes No Relation(s)_____

Blindness Yes No Relation(s)_____

Cataracts Yes No Relation(s)_____

Glaucoma Yes No Relation(s)_____

Macular degeneration Yes No Relation(s)_____

Retinal detachment Yes No Relation(s)_____

Do you drink alcohol? Yes No If yes, how many OUNCES/GLASSES per day?_____

Do you smoke? Yes No If yes, how many cigarettes per day?_____

Diabetes Yes No When was it diagnosed? _____Average daily glucometer reading_____
(list medication)
How is treated? (circle one) **Diet** **Oral Medication** _____**Insulin** how long on insulin _____

Chronic Fever, unexplained Weight Loss/Gain, fatigue Yes No How long _____

Heart Disease (chest pain, irregular heartbeat, heart attack) Yes No How long _____

High Blood pressure (hypertension) average BP _____ Yes No How long _____

Respiratory (shortness of breath, asthma, emphysema) Yes No How long _____

Intestinal (heartburn, abdominal pain, diarrhea, vomiting) Yes No How long _____

Skin (rashes, excessive dryness, skin cancer) Yes No How long _____

Ears/Nose/Throat (hearing loss, sinus, throat problems) Yes No How long _____

Genitourinary/Dialysis (kidney failure, blood in urine) Yes No How long _____

Bones, Joints, Muscles (arthritis, joint pain, swelling) Yes No How long _____

Neurologic (stroke, numbness, headaches, paralysis) Yes No How long _____

Blood disease/Lmphatic
(node swelling, HIV+, hepatitis, sickle cell) Yes No How long _____

Allergic/Immunologic (lupus and Sjogren's) Yes No How long _____

Psychiatric (depression, anxiety) Yes No How long _____

Endocrine disease (thyroid) Yes No How long _____

Are you pregnant? Yes No How many months along_____

Do you have FOOD ALLERGIES? Yes No Please list __ _____

Have you had an ALLERGIC REACTION to Medications? Yes No Please list _____

Have you had an ALLERGIC REACTION to Latex/Tape? Yes No Please list _____

Have you had an ALLERGIC REACTION to injectable Dye? Yes No Please list _____

Past **HOSPITALIZATIONS/SURGERY/MAJOR ILLNESSES/INJURIES** Yes No Please list _____

_____

LIST ALL PRESCRIBED MEDICATIONS, OVER THE COUNTER, SUPPLEMENTS-MINERAL/VITAMINS

_____

_____

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