Patient's Name ____ Date ____________________

OCULAR HISTORY QUESTIONNAIRE

What ocular problem brings you here? ____

	Y	N	
Do you wear glasses for vision?	____	____	
Do you wear contact lenses?	____	____	➞ What brand & prescription? ____________________
Do you have glaucoma?	____	____	➞ How is it being treated? ____________________
Have you had LASIK surgery?	____	____	➞ What date? ____________________
Have you had cataract surgery?	____	____	

Which eye:

Right ____ Date of surgery ______________ Surgeon: ________________

Left ____ Date of surgery ______________ Surgeon: ________________

When was your last eye exam? ________________________ Eye Doctor: ________________

What did the doctor tell you? ____

MEDICAL HISTORY

Name of medical doctor: ____

Address: ____

Phone Number: ____

	Y	N
Were you born prematurely?	____	____

Have you ever suffered from any of the following? (Please checkmark those which apply):

	Y	N		Y	N
Headaches, Sinus, Tonsillectomy	____	____	Joint disease, arthritis	____	____
High cholesterol	____	____	Stroke or neurological disorder	____	____
Heart condition	____	____	History of psychological disorder	____	____
High blood pressure	____	____	Thyroid disease	____	____
Circulatory problems	____	____	Diabetes	____	____
Lung disease	____	____	If yes, how long?		
Ulcers, Liver, Gall bladder disease	____	____	Last blood sugar results:		
Kidney, Bladder, Prostate disease	____	____	Bleeding disorder, Anemia	____	____
Do you smoke?	____	____	AIDS or infectious disease	____	____
Do you drink?	____	____	Cancer	____	____

List **ALL** medications presently taking, please include eye drops:

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

List any medication allergies: ____

FAMILY HISTORY

Is there family history of:	Y	N	
Cataracts	____	____	Relative: ____________________
Glaucoma	____	____	Relative: ____________________
Retina Disease	____	____	Relative: ____________________
Diabetes	____	____	Relative: ____________________
Hypertension	____	____	Relative: ____________________
Anemia	____	____	Relative: ____________________
Other eye or systemic disease	____	____	Relative: ____________________