

CORNEA CONSULTANTS OF ARIZONA – MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date: _____

Date of Last Eye Exam _____ Exam Done By: _____

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

List any medications you currently take (prescription and over-the-counter):

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

Do you have **ALLERGIES** to any medications? YES NO

If **YES**, list the medications with reaction: _____

Do you currently have any problems in the follow areas? If “YES”, please circle:

Loss of Vision, Loss of Side Vision, Dryness, Redness, Fluctuating Vision, Mucous Discharge, Sandy or Gritty Sensation, Distorted Vision (Halos), Glare/Light Sensitivity, Tired Eyes, Itching, Burning, Eye Pain, Droopy Eyelid, Blurred Vision, Excessive Tearing or Watering, Foreign Body Sensation, Double Vision, Lid Soreness/Redness, None of the Above, Other _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Are the problems you are having the result of an accident? YES NO

If yes, Work Accident Auto Accident Other Accident

Have you or any member of your family been diagnosed with any of the following?

M=Mother F=Father S=Sibling GP=Grandparent

	SELF	FAMILY		SELF	FAMILY
CATARACTS			CONJUNCTIVITIS (PINK EYE)		
GLAUCOMA			RETINAL DISEASE		
CORNEAL DYSTROPHY			RETINAL DETACHMENT		
KERATACONUS			INJURY		
DRY EYE			LAZY/CROSSED EYE		
INFECTION EYE LID			OTHER		

DO NOT FILL OUT OCULAR SURGERY FORM BELOW

Date	Ocular Surgery	Surgeon	PO exp. date

(OVER)

List any surgeries you have had (Open heart, tonsillectomy, appendectomy)

1. _____ 4. _____ 7. _____
 2. _____ 5. _____ 8. _____
 3. _____ 6. _____ 9. _____

Do you smoke? YES NO If yes, what quantity? _____

Do you drink alcohol? YES NO If yes, what quantity? _____

Have you ever had a blood transfusion? YES NO Date _____

Current Occupation _____

Living Arrangments: _____

Have you or a family member been diagnosed with any of the following? Please check as they apply:

M=Mother F=Father S=Sibling GP=Grandparent

	SELF	FAMILY		SELF	FAMILY
HEART DISEASE			SKIN		
Chest pain-angina			Acne		
Irregular heart beat			Rash		
Heart murmur			Skin cancer		
High blood pressure			Other		
Other			BLOOD/LYMPH		
LUNG DISEASE			Anemia		
Asthma			Leukemia		
COPD			Other		
Chronic cough			ALLERGIC/		
Shortness of breath			IMMUNOLOGIC		
Other			Hay Fever		
GASTROINTESTINAL			Lupus		
Stomach ulcers			Sjogrens		
Intestinal disease			Other		
Other			NEUROLOGICAL		
DIABETES			Multiple sclerosis		
Type 1 insulin			Black out		
Type 2 diet/pill			Recent fall		
MUSCLES, BONES			Head injury		
JOINTS			Other		
Arthritis			PSYCHIATRIC		
Osteo			Depression		
Rheumatoid			Other		
Other					

Physician's signature _____ Tech: _____ Date: _____