

## Shoreline Eye Group Medical History Questionnaire

Patient name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Do you wear Glasses  yes  no Contact Lenses  yes  no

Who is your primary care doctor? \_\_\_\_\_

Do you see any specialists?  Yes  No

If yes list specialists: \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

### Pharmacy information:

Name of pharmacy: \_\_\_\_\_ Location of pharmacy: \_\_\_\_\_

### DO YOU HAVE ANY OF THESE EYE SYMPTOMS?

- Blurred distance vision       Glare, halos around lights
- Blurred reading vision       Itching or burning eyes
- Constant double vision       Eye mattering or tearing
- Flashing lights or floaters       Foreign body sensation
- Red eyes       Dry eye
- Headaches       Eye pain

### HAVE YOU EVER HAD ANY OF THESE EYE

#### PROBLEMS?

- Cataract       Serious eye injury
- Glaucoma       Iritis / uveitis
- Macular degeneration       Lid lesions
- Lazy eye / patched as a child       Retinal detachment
- Other: \_\_\_\_\_       Eye surgery

### DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS INCLUDING OVER THE COUNTER MEDICATION OR LATEX?

None known       Yes, which ones?

Medication Name      What reaction did you have?


### HAVE YOU EVER HAD ANY OF THESE

#### CONDITIONS?

- Arthritis       Lyme disease       Auto immune disease
- Diabetes       Dizziness       High blood pressure
- Cancer       Allergies       Heart disease
- Migraines       AIDS, HIV       Lung disease
- Stroke       Hepatitis C       Thyroid disease
- MRSA       Prostate
- Do you have a pace maker or defibrillator?

### WHICH EYE MEDICATIONS OR OTHER EYE DROPS DO YOU CURRENTLY TAKE?

None       Artificial Tears

Medication Name	How many times/day
	1 2 3 4 at bedtime
	1 2 3 4 at bedtime
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### HAVE MEMBERS OF YOUR FAMILY HAD ANY EYE DISEASES?

(This would be your father, mother, sister, brother, and grandparents)

- Glaucoma       Diabetic eye disease or diabetes
- Cataract       Crossed eyes       Macular degeneration
- Iritis / uveitis       Blindness       Retinal detachment
- Poor vision       Other: \_\_\_\_\_

**Please Proceed to Other Side**

