

Shoreline Eye Group Medical History Questionnaire

Patient name: _____ Today's date: _____

Date of Birth _____ Who is your medical doctor? _____

Do you wear Glasses yes no Contact Lenses yes no

What is the main reason for your visit today? _____

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

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?
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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
	1 2 3 4 at bedtime
	1 2 3 4 at bedtime
	1 2 3 4 at bedtime

WHICH OTHER MEDICATIONS OR SUPPLEMENTS DO YOU CURRENTLY TAKE?

- None Aspirin on a daily basis?

Medication Name	Amount	How many times/day
		1 2 3 4 at bedtime
		1 2 3 4 at bedtime
		1 2 3 4 at bedtime
		1 2 3 4 at bedtime
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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

HAVE YOU EVER HAD ANY OF THESE CONDITIONS?

- None Lyme disease Auto immune disease
- Stroke Dizziness High blood pressure
- Arthritis Allergies Heart disease
- Diabetes AIDS, HIV Lung disease
- Cancer Hepatitis C Thyroid disease
- Migraines MRSA Prostate
- Other: _____

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 LIST ANY SURGERIES YOU HAVE HAD:

Type of Surgery	Year

Please Proceed to Other Side

