Oregon
Eye Specialists, PC
PHYSICIANS & SURGEONS
DISEASES & MICROSURGERY OF THE EYE
www.oregoneyes.net

MEDICAL HISTORY QUESTIONNAIRE

Full Legal Name: _____ **Sex:** ☐ **M** ☐ **F** **Age:** _____ **Date:** _____
Date of Birth: _____
Primary Care Doctor: _____
List all current & previous **non-ocular** conditions, injuries, surgeries: _____

_____

List all current & previous **ocular** conditions, injuries, surgeries: _____

_____

_____

Have you ever had any of the following eye procedures: _____**LASIK** _____**PRK** _____**RK**

Current Medications (include eye-drops & over the counter):

_____

_____

Allergies to medications: _____

_____

Social History:

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
Do you currently drive? ☐ Yes ☐ No _____ Daytime _____Nighttime
If applicable, are you pregnant or planning a pregnancy? ☐ Yes ☐ No

Occupation: _____ or ___ Retired

Review of systems/Please check if you have any of these conditions today:

Environmental or Seasonal Allergies	☐ Yes	☐ No	Loss of Smell	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Immune Disorder	☐ Yes	☐ No	Loss of Hearing	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Poor Control of Blood Pressure	☐ Yes	☐ No	Reflux	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Genitourinary Discharge	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Difficulty Urinating	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Cough	☐ Yes	☐ No
Poor Control of Blood Sugar	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Thyroid Abnormalities	☐ Yes	☐ No	Rosacea	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No						

Family History / Do any of your blood relatives have the following conditions:

Blindness	☐ Yes	☐ No	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma	☐ Yes	☐ No	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration	☐ Yes	☐ No	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes	☐ Yes	☐ No	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment	☐ Yes	☐ No	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Do you have trouble with any of your daily activities due to your vision: ☐ Yes ☐ No
If yes, what activities:

_____

_____

Check if you take: ____ Blood Thinners ____ Flomax/tamsulosin
Check if you have: ____ MRSA ____ Defibrillator ____ Pacemaker ____ Heart Valve