Oregon
Eye Specialists, PC

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Full Legal Name: _____ Sex: ☐ M ☐ F Age: _____

Date of Birth: (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___

Primary Care Doctor: _____

List all current and previous **non-ocular** conditions, injuries, surgeries: _____

_____

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

_____

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

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

_____

_____

Allergies to medications: _____

_____

For patients 65 and older:

Do you have and Advanced Directive? ☐ Yes ☐ No Have you had a Pneumonia Vaccination? ☐ Yes ☐ No

SOCIAL HISTORY –

Do you Smoke ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No Occupation: _____ or Retired ☐

Do you currently drive? ☐ Yes ☐ No ☐ Daytime ☐ Nighttime

Are you pregnant or planning a pregnancy? ☐ Yes ☐ No

REVIEW OF SYMPTOMS *Please check if you have any of these conditions today:*

Environmental/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	Seizures	☐ 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 *Have any of your blood relatives had 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 ☐ Defibrilator ☐ Pacemaker ☐ Heart Valve