Name:
Chart:
Date:

THE RETINA GROUP OF WASHINGTON

MEDICAL HISTORY QUESTIONNAIRE

Medical History Questionnaire
Side 1

Today's Date: _____

Last Name _____ First Name _____ MI _____

Please answer the following questions about your current eye problems and medical history:

1. What problems are you **CURRENTLY** having with your eyes?

		Which eye?	When did the trouble begin?
☐ floaters/spots	☐ pain		
☐ flashing lights	☐ sensitivity to light/glare	☐ Right	
☐ blurred vision	☐ poor depth perception		
☐ distortion/waviness	☐ trouble with colors	☐ Left	
☐ loss of side vision	☐ other _____		

2. Have you had any eye problems in the past (e.g., cataract, glaucoma, retina problems, eye surgery, etc.,)?
☐ Yes ☐ No If yes, please explain: _____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, asthma, etc.)?
☐ Yes ☐ No If yes, please explain: _____

4. Current medications, including eye drops: _____

5. Do you have any allergies to medications? _____

6. Have you had any of the following problems?

	Yes	No	If yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue?	☐	☐	
Ear/nose/throat problems (e.g. hearing loss, sinus problem)?	☐	☐	
Heart problems (e.g. chest pain, irregular heartbeat)?	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, asthma, bronchitis)?	☐	☐	
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?	☐	☐	
Urinary problems (e.g. pain or discomfort, bladder infections)?	☐	☐	
Skin disease (e.g. rashes, eczema, dermatitis)?	☐	☐	
Musculoskeletal problems (e.g. muscle aches arthritis, swollen joints)?	☐	☐	
Neurologic problems (e.g. numbness, weakness, paralysis, headaches)?	☐	☐	
Psychiatric problems (e.g. depression, anxiety)?	☐	☐	

7. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
☐ Yes ☐ No If yes, please explain: _____

8. Do you ☐ smoke? If yes, how much? _____ ☐ Drink alcohol? If yes, how much? _____