Ophthalmology Consultants of Fort Wayne, P.C.

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MEDICAL HISTORY QUESTIONNAIRE

OCULAR HISTORY

CURRENT OR PREVIOUS	YES / NO	EYE	DIAGNOSIS	CURRENT TREATMENT/ PREVIOUS SURGERY	WHEN?
Eye Disease	☐ Yes ☐ No				
Eyes Injury	☐ Yes ☐ No				
Eye Surgery	☐ Yes ☐ No				

MEDICAL HISTORY

DO YOU NOW, OR HAVE YOU EVER HAD:	YES / NO	CURRENT TREATMENT/PREVIOUS SURGERY	WHEN?
Diabetes Type?	☐ Yes ☐ No		
Heart Disease Pacemaker/Defibrillator	☐ Yes ☐ No ☐ Yes ☐ No		
High Blood Pressure	☐ Yes ☐ No		
High Cholesterol	☐ Yes ☐ No		
Kidney Failure (Dialysis ☐ Yes ☐ No)	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Thyroid Disease: ☐ Overactive ☐ Underactive	☐ Yes ☐ No ☐ Yes ☐ No		
Cancer or Tumor Type?	☐ Yes ☐ No		
Females: ☐ Pregnant ☐ Nursing	☐ Yes ☐ No		
Other:			

Family History: **Relationship**

☐ Yes ☐ No High Blood Pressure _____
☐ Yes ☐ No Diabetes _____
☐ Yes ☐ No Cancer _____
☐ Yes ☐ No Glaucoma _____
☐ Yes ☐ No Cataracts _____
☐ Yes ☐ No Retinal Disease _____
☐ Yes ☐ No Other eye/medical problems (please specify) _____

Social History

Use of Tobacco: ☐ Current ☐ Former
☐ Never Amt: _____
Alcohol: ☐ Yes ☐ No Amt: _____