

# MATOSSIAN EYE ASSOCIATES MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Current Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "YES", provide information:

### EXPLANATION OF PROBLEM

	NO	YES	
<b>Eyes</b>			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision, halos, or glare	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashing lights or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dark spots or veils over vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossing or drifting of eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness or Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching or Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Fever, Weight loss/gain or fatigue</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Skin</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Ears, nose, mouth, throat</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Cardiovascular (heart/blood vessels)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Respiratory (lungs/breathing)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Gastrointestinal (stomach)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Genito-urinary</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Males</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Females</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Musculoskeletal (bones-joints-muscles)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neurological (headaches)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Endocrine (diabetic-thyroid)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Bleeding tendency</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Seasonal allergies, hayfever, recent cold</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Other symptoms not listed above</b> _____			_____
_____			_____
_____			_____

**PAST HISTORY**

**Please circle any allergies that you have:**

- Local anesthetics
- Penicillin
- Sulfa or other antibiotics
- Radiologic Dye

- Aspirin
- Codeine or narcotics
- Shellfish
- Other \_\_\_\_\_

- Flourescein Dye
- Iodine/Betadine
- Latex

**Current Eye Medications (and dosage if known)**

_____	_____
_____	_____
_____	_____

**Current medications, vitamins, or herbal supplements (and dosage if known)**

_____	_____
_____	_____
_____	_____

**Ocular history**

**Please Circle any condition that applies to you**

- |                                  |  |
|----------------------------------|--|
| Date of your last eye exam _____ | Doctor _____                           |
| Lazy eye _____                   | Cataract _____                         |
| Glaucoma _____                   | Macular degeneration/Pucker/Hole _____ |
| Retinal detachment/tear _____    | Serious eye injury _____               |
| Crossed eyes _____               | Lid problems _____                     |
| Diabetic Retinopathy _____       |  |
| Other _____                      |  |

Eye surgery including laser surgery \_\_\_\_\_ (if yes list dates, eye, and surgeon below)

**Medical history**

**Please circle any condition that applies to you**

- |  |                               |
|--|-------------------------------|
| Asthma _____   | Emphysema _____               |
| High blood pressure _____  |                               |
| Heart disease/angina/heart attack/irregular heart beat/atrial fibrillation/stents/open heart surgery or artificial valve _____ | Stroke/TIA _____              |
| Thyroid disease _____  | Cancer _____                  |
| Anemia _____   | Arthritis/Rheumatoid _____    |
| HIV _____  | High cholesterol _____        |
| Hepatitis C _____  | Kidney Disease/Dialysis _____ |
| Sinus Infection _____  | Other _____                   |

**If answer to Diabetes is No, skip to page 3.**

**No Yes**

- Insulin required # of years insulin \_\_\_\_\_
- No Insulin required
- Type I (Childhood onset)
- Type II (Adult onset)

Age at onset: \_\_\_\_\_

Total # years, diabetic: \_\_\_\_\_

Last Hemoglobin A1C (less than 7.0%) \_\_\_\_\_

**If answer to Glaucoma is No, skip to page 3.**

Age at Diagnosis \_\_\_\_\_

Highest intraocular pressures (if known) \_\_\_\_\_

Previous glaucoma drops used (if known) \_\_\_\_\_

Any allergies to glaucoma medications \_\_\_\_\_

Other medical conditions – Circle any that apply

Hypotension (low blood pressure) – Migraines –

Steroid use (creams, inhaler, pills) – Raynaud’s

syndrome -Trauma (serious) – Sleep apnea

**Other medical conditions not listed above**

\_\_\_\_\_  
\_\_\_\_\_

**Surgeries**

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

**Any one in your family with any of the following:**

Lazy eye \_\_\_\_\_  
Glaucoma \_\_\_\_\_  
Retinal detachment \_\_\_\_\_  
Cancer \_\_\_\_\_  
Heart disease \_\_\_\_\_  
Kidney disease \_\_\_\_\_  
Blindness \_\_\_\_\_

Cataract \_\_\_\_\_  
Macular degeneration \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Diabetes \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Stroke \_\_\_\_\_  
Other \_\_\_\_\_

**SOCIAL HISTORY**

Occupation \_\_\_\_\_

	<b>NO</b>	<b>YES</b>	
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how old are your current glasses? _____
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
Soft <input type="checkbox"/> hard <input type="checkbox"/> gas permeable <input type="checkbox"/>	<input type="checkbox"/>		
Daily wear or extended wear? _____			
Age of current contact lenses _____			
Method of sterilizing/product name _____			
Do you drink alcohol? <input type="checkbox"/>	<input type="checkbox"/>		Drinks per day _____ or drinks per week _____
Do you smoke? <input type="checkbox"/>	<input type="checkbox"/>		Packs per day _____ Number of years _____
Have you quit smoking? <input type="checkbox"/>	<input type="checkbox"/>		How many years ago _____
Do you use drugs? <input type="checkbox"/>	<input type="checkbox"/>		