LEVIN EYE CARE

Ocular and Medical History Questionnaire

Name:_____ **Date:**_____ **Age:** _____

Please circle the conditions below that apply to you, and write any additional information about the condition in the space provided.

Eye Diseases/Problems:

Cataracts _____
Glaucoma _____
Macular Degeneration _____
Dry Eye _____
Lazy Eye/Amblyopia _____
Eye Surgery _____
Retinal Disease _____
Floaters/Flashes _____
Corneal Dystrophy _____
Eye Injury _____
Other _____
_____

Systemic Diseases/Problems:

Diabetes _____
High Blood Pressure _____
High Cholesterol _____
Thyroid Disease _____
Heart Disease _____
Arthritis _____
Asthma _____
Allergies _____
STDs/HIV _____
Other _____

Medications: *(Please list ALL medications you are taking, including eye drops)*

_____
_____
_____
_____
_____
_____

Allergies to Medications: *(Please list)*

_____
_____
_____
_____

Latex Allergy **Yes** ☐ **No** ☐

Family Ocular/Medical History: (*Please circle all that apply to your parents, grandparents and/or siblings*)

Glaucoma Cataracts Macular Degeneration Retinal Disease/Detachment

Diabetes High BP Heart Disease

Review of Systems: (*Please check yes or no to the following conditions*)

Yes	No		Yes	No	
☐	☐	GENERAL: Weight Loss, Fever, Headache	☐	☐	NEUROLOGIC: Paralysis, Numbness
☐	☐	EAR/NOSE/THROAT: Hearing loss, Sinus	☐	☐	SKIN: Rashes, Eczema
☐	☐	HEART: Chest Pain, Irregular Heart Rate	☐	☐	PSYCHIATRIC: Depression, Anxiety Mental Illness
☐	☐	RESPIRATORY: Shortness of Breath, Wheezing Asthma, Cough	☐	☐	ENDOCRINE: Diabetes, Thyroid
☐	☐	DIGESTIVE: Heartburn, Diarrhea	☐	☐	CANCER: Any Type
☐	☐	MUSCLES: Arthritis, Muscle Aches	☐	☐	BLOOD: Anemia, Sickle Cell, Bleeding problem
☐	☐	OTHERS: (please list)			

Social History:

Do you smoke: ☐ Yes ☐ No Do you drink alcohol: ☐ Yes ☐ No Recreational Drugs: ☐ Yes ☐ No