Barenburg Eye Associates

Ocular and Medical History Questionnaire

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

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

Eye Disease/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 Blood Pressure Heart Disease Stroke

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, Psoriasis
❒	❒	HEART: Chest Pain, Irregular Heart Rate	❒	❒	PSYCHIATRIC: Despression,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 problems
❒	❒	OTHER: (*please list*)			

Social History:

Do you smoke? Yes ❒ No ❒ Do you drink alcohol? Yes ❒ No ❒ Recreational Drugs: Yes ❒ No ❒