Glaucoma Institute of Austin
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Name: _____ Date: _____

Medical Questionnaire:

1) Have you ever been diagnosed with any eye disease? By whom and when?
( ) Glaucoma ( ) Corneal Disease ( ) Retina ( ) Macular Degeneration
Please describe: _____

2) Have you had any previous eye injuries? ( ) Yes ( ) No If yes, please describe: _____

_____

3) Are you using any EYE medications? ( ) Yes ( ) No If yes, what? _____

_____

4) Have you ever had Laser procedures done to your eyes? ( ) Yes ( ) No If yes, what kind, by whom, and when?

_____

5) Have you ever had any Eye surgeries? ( ) Yes ( ) No If yes, what kind, by whom and when?

_____

6) Do you have any current medical problems? ( ) Yes ( ) No If yes, what? _____

_____

7) Do you take any medications? ( ) Yes ( ) No If yes, what? _____

_____

8) Are you allergic to any medications? ( ) Yes ( ) No If yes, what? _____

9) Do you use Tobacco? ( ) Yes ( ) No How much? _____ How often? _____

10) Do you drink Alcohol? ( ) Yes ( ) No How much? _____ How often? _____

11) Do you use recreational drugs? ( ) Yes ( ) No How much? _____ How often? _____

12) Any family history of: ( ) Glaucoma ( ) Corneal Disease ( ) Retina ( ) Other
Please describe: _____

Review of Systems, any recent problems with:

1) Constitutional:
( ) Fever
( ) Weight loss
( ) Other

2) **EYES**
( ) Blurred Vision
( ) Double Vision
( ) Peripheral loss
( ) Halos
( ) Pain
( ) Discharge
( ) Glare
( ) Other

3) Ears, Nose, Throat
( ) Pain
( ) Discharge
( ) Other

4) Cardiovascular:
( ) Chest Pain
( ) Shortness of breath
( ) Irregular heart beat
( ) High blood pressure
( ) High cholesterol

5) Respiratory:
( ) Cough
( ) Shortness of breath
( ) Asthma
( ) Other

6) Gastrointestinal:
( ) Diarrhea
( ) Constipation
( ) Stomach Pain
( ) Bowel habits changed
( ) Ulcers
( ) Other

7) Musculoskeletal
( ) Weakness
( ) Joint pain
( ) Decreased range of motion
( ) Plaquenil use
( ) Rheumatoid arthritis

8) Hematologic/Lymphatic
( ) Anemia
( ) Blood disease
( ) Easy bleeding/bruising
( ) Swollen lymph nodes
( ) Other

9) Integumentary (Skin)
( ) Masses
( ) Tumors
( ) Pigmented lesion
( ) Rash
( ) Other

10) Neurologic
( ) Weakness
( ) Tingling
( ) Numbness
( ) Other

Have you ever had:
( ) Loss of consciousness
( ) Blood transfusion
( ) Low blood pressure
( ) Needed CPR
( ) Steroid use
( ) Reynaud's
( ) Migraines

I personally performed or reviewed all required elements of the history.
Physician's Signature:
_____
Date: ___/____/_____
Tech Initials:

Patient's Signature: _____