Buffalo Eye Center Medical History Questionnaire

Chart #_____

Name:_____ Date :_____

DOB:_____

Please Circle ALL that Apply

General Health: Fatigue Fever Recent Illness Weight changes +/- ____ **NONE**

ENT: Earache Stuffy Nose Hearing Loss Dry Mouth **NONE**

Cardiovascular: Hypertension A-FIB CAD CHF MI MVP High Cholesterol Heart Attack Irregular Pulse **NONE**

Respiratory: Asthma Emphysema COPD Sleep Apnea Shortness of Breath Cough Congestion **NONE**

Gastrointestinal: Celiac Crohn's Ulcer Reflux IBS Colitis Constipation Diarrhea **NONE**

Muscular: Arthritis (RA / OA / PSA) Fibromyalgia Joint Pain/Swelling Hernia(_____) **NONE**

Skin: Rash Rosacea Raynaud's Sjogren's Cancer(Melanoma/Basal) Psoriasis Acne **NONE**

Neurology: Stroke Seizures Parkinson's Migraine Headaches Numbness TIA TBI CVA **NONE**

Psychological: Anxiety Depression PTSD Insomnia Other: _____ **NONE**

Endocrine: Pre-Diabetes Diabetes Type 1 / Type 2 Insulin Yes / No Hyper/Hypothyroid Graves Hashimoto **NONE**

Hematology: Anemia Blood clots Bleeding problems Leukemia Transfusion **NONE**

Lymphatic: Edema Lymphoma **NONE**

Other:_____

Please list any current medications that you are taking including vitamins, supplements and OTC drugs.

DRUG NAME:	Dosage	DRUG NAME:	Dosage

Please list any drug allergies:

Prior Surgeries:

Eye Health: Flashing Lights Floaters Dryness Itching Pain Double Vision Vision Loss Trauma
Light sensitivity Injury:_____ Other:_____

Eye Diseases: Macular Degeneration Retinal Detachment Glaucoma Cataracts
Other:_____

Eye Surgeries: Cataracts Retinal Glaucoma
Laser Surgery:_____ Date:_____

Family Medical History: Arthritis Blindness Cataract Cancer:_____ Diabetes Glaucoma
Macular Degeneration Hypertension Stroke Thyroid Other:_____

Social History:

Smoking: Current Never Former → When did you stop? _____
Alcohol: Current Never Former→ When did you stop? _____
Recreational Drugs: Never Former→ When did you stop? _____

Status: Married Single Divorced

Driving: Daytime Nighttime Both