

Lancaster Retina Specialists

2150 Harrisburg Pike, Suite 370
Lancaster, PA 17601 (717)399-8790

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ Date: _____

DOB: _____ Sex: M() F()

Current Eye Problems: _____

Who is your family physician? _____

Who is your eye doctor? _____

Name of your Pharmacy, City and Phone # : _____

Emergency Contact and Phone #: _____

YOUR MEDICATIONS

List all medications you currently take and your dosage:

_____	_____
_____	_____
_____	_____
_____	_____

Are you on a blood thinner? Yes () No () If yes, which one? _____

List all eye drops you are currently using:

_____	_____
_____	_____
_____	_____

Drug Allergies: _____

MEDICAL HISTORY

Do you have a problem with:

	Yes	No	If yes, explain		Yes	No	If yes, explain
Eyes	___	___	_____	Weight Loss/Gain	___	___	_____
Ears/Nose/Throat	___	___	_____	Diabetes	___	___	_____
Headaches	___	___	_____	Cancer	___	___	_____
Lungs/Breathing	___	___	_____	Cholesterol	___	___	_____
Heart Disease	___	___	_____	Thyroid	___	___	_____
High Blood Pressure	___	___	_____	Kidney Disease	___	___	_____
Stomach	___	___	_____	Urinary	___	___	_____
Rheumatologic	___	___	_____	Blood Disorder	___	___	_____
Neurologic	___	___	_____	HIV/Hepatitis	___	___	_____
Psychiatric	___	___	_____	Infectious Disease	___	___	_____
Are you Pregnant?	___	___	_____	Skin Disease	___	___	_____

Other Medical Problems: _____

If diabetic how old were you when you were diagnosed with diabetes? _____

Please list all major illnesses: _____

PLEASE CONTINUE TO PAGE 2

OPERATIONS

List any previous operations, general and eye related

Date

SOCIAL HISTORY

Marital Status S M W D Occupation: _____

Do you use drugs Yes () No () If yes, how much per day _____

Do you smoke Yes () No () If yes, how much per day _____

Do you drink alcohol Yes () No () If yes, how much per day _____

Did you smoke in past Yes () No () How long did you smoke? _____

YOUR EYE HISTORY

	RIGHT	LEFT		RIGHT	LEFT
Retinal Detachment	_____	_____	Amblyopia (lazy eye)	_____	_____
Diabetic Retinopathy	_____	_____	Cataract	_____	_____
Macular Degeneration	_____	_____	Glaucoma	_____	_____
Corneal Transplant	_____	_____	Vein Occlusion	_____	_____
Retinitis Pigmentosa	_____	_____	Iritis	_____	_____
Eye Injury	_____	_____	If yes, Date: _____ Describe: _____		
OTHER: _____					

FAMILY HISTORY

Do any family members (Mother, Father, Brother, Sister, Son or Daughter) have:

	Yes	No	Relationship
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
Stroke	_____	_____	_____
Heart Disease	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Retinal Detachment	_____	_____	_____
Cataract	_____	_____	_____
Amblyopia	_____	_____	_____
Arthritis	_____	_____	_____
Hypertension	_____	_____	_____
Kidney Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
Uveitis	_____	_____	_____
Headaches/Migraines	_____	_____	_____

Patient Signature: _____ Date: _____

****Please Return To The Front Desk****