BAYSHORE OPHTHALMOLOGY
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Date:** _____

Drug Allergies:	**Reaction:**	**Severity (please circle):**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Current Eye Medications (with dosage): □ No current eye medications

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list) □ No current systemic medications

_____ _____ _____

_____ _____ _____

List any Eye Injury or Eye Surgery you have had: □ No prior eye surgery

_____ _____

_____ _____

Other Medical History: □ No history of illnesses

□ Alzheimer's/Dementia	□ Diabetes Type 1	□ Lung Disease
□ Anemia	□ Diabetes Type 2	□ Lupus
□ Anxiety	□ Dry Eye	□ Liver Disease
□ Arthritis	□ Eczema	□ Meningitis
□ Arrhythmia	□ Fibromyalgia	□ Migraine
□ Asthma	□ Hearing Loss	□ MRSA
□ Bleeding Disorder	□ Hepatitis A/B/C	□ Psychiatric Disorder
□ Cancer	□ High Blood Pressure	□ Skin Cancer
□ Congestive Heart Failure	□ High Cholesterol	□ Stroke
□ COPD	□ Kidney Disease	□ Thyroid Disease

Other: _____

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

Family History:

□ Arthritis	□ Diabetes	□ High Blood Pressure	□ Macular Degeneration
□ Blindness	□ Glaucoma	□ Kidney Disease	□ Retinal Disease
□ Cancer	□ Heart Disease	□ Lazy Eye	□ Stroke

Other: _____

Social History: (Please mark all that apply)

Smoking: □ current every-day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and often? _____

Drug Use: □ Yes □ No If yes what and how often? _____

Review of Systems: (Please mark all that apply)

In the past year, have you fallen 2 or more times? Yes No Have you received the COVID-19 vaccine? Yes No

In the past year, have you had the Influenza vaccine? Yes No

In the past year, have you had the Pneumonia vaccine? Yes No