METROPOLITAN EYE CENTER Medical History Questionnaire Date: _____

Name: _____ Date of Birth: ____ /____ /_____ MRN: _____

Primary Care Physician: _____ Referring Specialist: _____

Allergies to Medications? _____ ❒ None

Have you ever had the Pneumonia Vaccine? ❒ Yes ❒ No Flu shot? ❒ Yes ❒ No COVID Vaccine? ❒ Yes ❒ No

Have you ever Fallen? ❒ Yes ❒ No

Past Ocular History (Mark all that apply):

❒ Overall Healthy
❒ Amblyopia (Lazy Eye)
❒ Aphakia
❒ Astigmatism
❒ Cataracts
❒ Color Blind
❒ Crossed Eye
❒ Diabetic Retinopathy
❒ Dry Eyes
❒ Glaucoma
❒ Hyperopia (Farsighted)
❒ Iritis
❒ Keratoconus
❒ Macular Degeneration
❒ Myopia (Nearsighted)
❒ Optic Neuritis
❒ Retinal Detachment
❒ Trauma

Past Ocular Surgeries / Procedures (Mark all that apply):

❒ No prior ocular surgery
❒ Blepharoplasty
❒ Cataract Surgery
❒ Foreign Body Removal
❒ Glaucoma Stent
❒ Retinal Laser Surgery
❒ LASIK or PRK
❒ Punctal Plugs
❒ RK
❒ Strabismus/Muscle Surgery
❒ Trabeculectomy
❒ Vitrectomy (Glaucoma surgery)

Other: _____

Current Eye Medications: (Please List)

_____

_____

Systemic Illnesses / Infections (Mark all that apply):

❒ No history of illnesses
❒ Anemia
❒ Arthritis
❒ Rheumatoid Arthritis
❒ Arrhythmia
❒ Bleeding Disorder
❒ Cancer
❒ Congestive Heart Failure
❒ COPD
❒ Diabetes
❒ Eczema
❒ Fibromyalgia
❒ Headache
❒ Hearing Loss
❒ Hepatitis A / B / C
❒ Herpes Simplex
❒ Herpes Zoster / Shingles
❒ High Blood Pressure
❒ High Cholesterol
❒ Histoplasmosis
❒ HIV
❒ Kidney Disease
❒ Kidney Stones
❒ Liver Disease
❒ Lung Disease
❒ Lupus
❒ Meningitis
❒ Migraine
❒ MRSA
❒ Polymyalgia
❒ Psychiatric Disorder
❒ Skin Cancer
❒ Stroke
❒ Syphilis
❒ Thyroid Disease
❒ Toxoplasmosis

Ocular Significant Illnesses (Mark all that apply):

❒ Overall Healthy
❒ AIDS
❒ Diabetes
❒ Rheumatoid Arthritis
❒ Herpes
❒ HIV Positive
❒ Hypertension
❒ Hypothyroidism
❒ Lupus
❒ Multiple Sclerosis
❒ Sjogren's
❒ Graves Disease
❒ Hyperthyroidism

Other _____

General Surgeries / Operations (Please list):

_____

_____

_____

_____

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Current Medications and Supplements:

Name	Dosage	How Often	Name	Dosage	How Often

Have you ever taken prostate medicines? Please circle: Flomax, Tamsulosin, Uroxatral

Family History (other than yourself): (please circle applicable family members)		❒ Unknown Family History
❒ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased
❒ High Blood Pressure	Parent / Sibling / Maternal Grandparent / Paternal Grandparent	Living / Deceased

Social History (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 how often? _____

Recreational Drug use: ❒ Yes ❒ No if yes, how much and how often? _____

<table>
<tr>
<td rowspan="2">Vision and Eye History (Mark all that apply):
❒ Previous Eye Surgery
❒ Contact Lenses
❒ Pain
❒ Double Vision
❒ Glaucoma
❒ Cataract
❒ Macular Degeneration
❒ Dry Eyes
❒ Flashes
❒ Floaters</td>
<td>Respiratory (Mark all that apply):
❒ Cough
❒ Congestion
❒ Wheezing
❒ Asthma</td>
<td>Blood/Lymph Nodes (Mark all that apply):
❒ Easy Bruising
❒ Gums Bleed Easy
❒ Prolonged Bleeding
❒ Heavy Aspirin Use</td>
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<tr>
<td>Gastrointestinal (Mark all that apply):
❒ Heartburn
❒ Nausea/Vomiting
❒ Jaundice/Hepatitis</td>
<td>Musculoskeletal (Mark all that apply):
❒ Stiffness
❒ Arthritis
❒ Joint Pain/Swelling</td>
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<tr>
<td>Ear, Nose and Throat (Mark all that apply):
❒ Hard of Hearing
❒ Ring in Ears
❒ Vertigo</td>
<td>Urinary (Mark all that apply):
❒ Pain/Difficulty
❒ Blood in Urine
❒ History of Kidney Stones
❒ History of STD’s</td>
<td>Skin (Mark all that apply):
❒ Rash/Sores
❒ Lesions
❒ Hives/Eczema</td>
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<tr>
<td>Cardiovascular (Mark all that apply):
❒ Chest Pain
❒ Dizziness
❒ Fainting Spells
❒ Shortness of Breath
❒ Irregular Heartbeat
❒ Difficulty Laying Flat</td>
<td>Psychiatric (Mark all that apply):
❒ Anxiety/Depression
❒ Mood Swings
❒ Difficulty Sleeping</td>
<td>Neurological (Mark all that apply):
❒ Seizures
❒ Weakness/Paralysis
❒ Numbness
❒ Tremors</td>
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<tr>
<td>General (Mark all that apply):
❒ Fatigue/Weakness
❒ Fever
❒ Weight Gain/Loss</td>
<td>Endocrine (Mark all that apply):
❒ Increased Thirst
❒ Increased Hunger
❒ Increased Urination
❒ Increased Sweating
❒ Fingerail Changes</td>
<td>Immunologic (Mark all that apply):
❒ Hives
❒ Itching
❒ Runny Nose
❒ Sinus Pressure</td>
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</table>