

ALAN E. SOLINSKY, M.D.
Medical History Questionnaire

Name		Date of Birth:	
1. Please describe any concern or problem you have with your eyes:			
2. Date of last eye exam			
3. Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Make & power:	
4. Do you use any eyedrops? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list:			
5. Please list all medications you are currently taking, including birth control pills and non-prescription medications:			
6. Are you allergic to any medications or foods? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list:			
7. What is (was, if retired) your occupation?			
Do you have:	Yes	No	<i>Reserved for notes</i>
Decreased vision			
Blind spots in vision			
Poor side vision			
Poor night vision			
Poor color vision			
Poor depth perception			
Abnormal sensitivity to light			
Halos around lights			
Problems with glare			
Red eye			
Eye which bulges out			
Puffy eyes			
Eye discomfort			
Eye dryness			
Eye itching			
Pressure in or behind eye			
Mattering of eyes			
Tearing of eyes			
Pus around eyes			
Crusting or red eyelids			
Change in blinking			
Double vision			
Have you had:	Yes	No	
Blurred vision spells			
Decreased vision spells			
Fluctuating vision			
Floater in your vision			
Flashing lights			
Jagged lines in vision			
Eye surgery			
Eye injury			
Serious eye infection			
Spasm of eyelids			
Retraction of eyelids			
Lazy eyelids			
Abnormal pupil			
Cornea disease			
Glaucoma			
Cataract			
Retinal disorder			
Eye tumor			
In or out-turning of eye			
SOCIAL HISTORY			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How many packs per day?			
Do you consume two or more alcoholic drinks per day? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you concerned that your occupation adversely affects your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TURN OVER TO COMPLETE

REVIEW OF SYSTEMS (Patient History) - Please indicate if you have had problems in any of the following:					
	Yes	No		Yes	No
Respiratory (lungs/breathing)				Unusual Fatigue	
Asthma				Cholesterol Problems	
Emphysema				Skin	
Chronic Bronchitis				Gastrointestinal (stomach)	
Genitourinary				Liver Trouble	
Prostate Problems				Ulcers	
Kidney Trouble				Neurological	
Psychiatric				Seizures	
Cancer				Migraines	
Endocrine				Stroke	
Diabetes				Allergic/Immunologic	
Thyroid (hypo/hyper)				Head allergy symptoms	
Hematologic/Lymphatic				Seasonal allergies	
Transfusions				Fever	
Ears/Nose/Mouth/Throat				Weight Loss	
Chronic Cough				Tuberculosis	
Dry throat/mouth				Musculoskeletal	
Deafness				Rheumatoid arthritis	
Cardiovascular (heart)				Hepatitis A/B/C	
Atrial Fib				Pregnancy/Nursing	
Circulation Problems				Birth-Premature	
Pacemaker					
Other					

List all major illnesses and injuries including dates
List any surgeries you have had including dates

FAMILY HISTORY - Are you aware of your parents or siblings having any of the following?					
	Yes	No	Reserved for physician notes	Yes	No
Glaucoma				High blood pressure	
Blindness				Heart attacks	
Cataract				Stroke	
Retinal Detachment				Cancer	
Macular Degeneration				Kidney disease	
Lazy Eye/Crossed Eye				Arthritis	
Diabetes				Sjogrens syndrome	
Thyroid Disease				Lupus	

Patient Signature	Date
Reviewed by:	Date
Reviewed by:	Date
Reviewed by:	Date
Reviewed by:	Date
Reviewed by:	Date

TURN OVER TO COMPLETE