# GLAUCOMA CENTER OF TEXAS

MEDICAL HISTORY QUESTIONNAIRE

Date _____ Name _____ Age _____ Date of Birth _____

Height _____ Weight _____

What specific visual difficulties are you experiencing now? _____

_____

Have you ever had eye surgery? ☐No ☐Yes (please list) _____

_____

Please list any eye medications you are currently taking: _____

_____

Do you have any visual difficulty when driving? ☐No ☐Yes Describe: _____

**I. Past History:**

Drug Allergies/ Reactions: ☐No known drug allergies ☐Yes (please list) _____

_____

List any major illnesses and injuries (with dates): _____

_____

List any past surgeries (with dates): _____

_____

List any current medications:_____

_____

**II. Family History:**

| | | | Relation | | | | Relation |
|---|---|---|---|---|---|---|---|
| Cataracts | No | Yes | | Retinal Detachment | No | Yes | |
| Glaucoma | No | Yes | | Heart Disease | No | Yes | |
| Diabetes | No | Yes | | Eye Disorders | No | Yes | |
| High Blood Pressure | No | Yes | | Other | No | Yes | |
| Macular Degeneration | No | Yes | | | | | |

**III. Social History:**

Current Occupation: _____

Hobbies: _____

Do you drink alcohol? ☐No ☐Yes If yes, how often? _____

Do you smoke? ☐No ☐Yes. If yes, how many packs a day? _____

_____**OVER →**

Name: _____ Date: _____

**REVIEW OF SYSTEMS:** If you are having any problems in the following areas, circle and explain

| | |
|---|---|
| **CONSTITUTIONAL:** Fatigue, fever, night sweats, weakness, weight loss/gain,<br>Explain | ☐ None |
| **HEAD:** headaches, dizziness, vertigo, other<br>Explain: | ☐ None |
| **NECK:** pain, stiffness, lump in neck, other<br>Explain: | ☐ None |
| **EARS, NOSE, MOUTH, THROAT:** hearing loss, ringing, sore throat, nasal congestion, sinus problems, dry mouth, difficulty swallowing, hoarseness, other<br>Explain: | ☐ None |
| **CARDIOVASCULAR (HEART/BLOOD VESSELS):** irregular heart-beat**,** chest pain, shortness of breath, swelling of feet, exercise intolerance, other<br>Explain: | ☐ None |
| **ENDOCRINE:** diabetes, thyroid, on birth control, pregnancy, other<br>Explain: | ☐ None |
| **RESPIRATORY:** wheezing cough, asthma, COPD, emphysema, difficulty breathing<br>Explain: | ☐ None |
| **GASTROINTESTINAL:** nausea, vomiting, change in bowel habits, diarrhea, constipation, pain/cramps, other<br>Explain: | ☐ None |
| **GENITOURINARY:** frequency, burning, hesitancy, pain or bleeding on urination, stones, infections, incontinence, impotence, other<br>Explain: | ☐ None |
| **SKIN:** itching, rash, infection, ulcer, tumors (growths), other<br>Explain: | ☐ None |
| **BREASTS:** tenderness, swelling, lumps, discharge, other<br>Explain: | ☐ None |
| **BLOOD AND LYMPH NODES:** fever/chills, easily bruised, prolonged bleeding, skin hemorrhages, significant blood loss, swollen lymph nodes, other<br>Explain: | ☐ None |
| **BONES, JOINTS, MUSCLES:** muscle pain/cramps, joint pain/swelling, other<br>Explain: | ☐ None |
| **NERVOUS SYSTEM:** weakness in arms/legs, numbness/tingling, loss of consciousness, falls, difficulty walking, seizures tremors, neuralgia, other<br>Explain: | ☐ None |
| **PSYCHIATRIC:** disorientation, mood swings, anxiety, depression, hallucinations<br>Explain: | ☐ None |
| **ALLERGY/IMMUNOLOGY:** recurrent infections, hay-fever, hives, food allergy, other<br>Explain: | ☐ None |

Completed By: _____ Time: _____ Date: _____