



# 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

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

Completed By: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_