JAMES H. ZELLNER, M.D., F.A.C.S.

OPHTHALMOLOGY

MEDICAL HISTORY QUESTIONNAIRE

Full Legal Name: _____ Sex: ☐ M ☐ F Date of Birth: _____ Date: _____

If this is your first visit, please complete:

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other: _____

Date of last eye exam: _____ Where was this done (doctor/clinic)? _____

Primary Care Doctor: _____

Pharmacy: _____

Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Rapaflo ☐ Uroxatral
☐ Minipress ☐ Cardura ☐ Hytrin ☐ Avodart

Eye Medications:

_____

_____

Current Medications (prescription, over the counter, vitamins, homeopathic):

_____

_____

Allergies to medications: _____

EYE HISTORY

Dry Eyes:	☐ No	☐ Yes	If yes:	☐ Right	☐ Left
Glaucoma:	☐ No	☐ Yes	If yes:	☐ Right	☐ Left
Macular Degeneration:	☐ No	☐ Yes	If yes:	☐ Right	☐ Left
Diabetic changes:	☐ No	☐ Yes	If yes:	☐ Right	☐ Left
Retinal Detachment or Retinal Tear:	☐ No	☐ Yes	If yes:	☐ Right	☐ Left
Other:					

EYE SURGERIES

Cataract:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Glaucoma surgery:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Retinal Laser:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Diabetic changes:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Retinal Detachment repair:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Lid surgery:	☐ No	☐ Yes	If yes:	☐ Right	Date	☐ Left	Date
Cornea Surgery:	☐LASIK	☐ PRK	☐ RK	☐ AK	☐ Transplant		
Other:							
Any Eye Trauma:	☐ No	☐ Yes	If yes:				

MEDICAL HISTORY

Diabetes:	☐ No	☐ Yes	☐ Insulin	☐ Non-Insulin	☐Borderline	☐Diet Controlled
High Blood Pressure:	☐ No	☐ Yes				
High Cholesterol:	☐ No	☐ Yes				
Heart Disease:	☐ No	☐ Yes	If yes	Explain:		
COPD/Asthma:	☐ No	☐ Yes	If yes:	Explain		
Auto-immune:	☐ No	☐ Yes	If yes:	Explain		
Cancer:	☐ No	☐ Yes	If yes:	Explain		
Other:						

SURGICAL HISTORY

Heart Surgery:	☐ No	☐ Yes	If yes:	Explain
Appendectomy:	☐ No	☐ Yes		
Tonsillectomy:	☐ No	☐ Yes		
Radiation/Chemotherapy:	☐ No	☐ Yes		
Other:				
Trauma (car accident/head injury):	☐ No	☐ Yes	If yes	Explain

Please check any of the following conditions that you have TODAY:

General:	☐ fever	☐ fatigue	☐ cancer	
Ears, Nose, Throat:	☐ earache	☐ nasal congestion	☐ pain	
Cardiovascular:	☐ chest pain	☐ high blood pressure	☐ irregular/ rapid heartbeat	
Respiratory:	☐ asthma	☐ emphysema	☐ shortness of breath	
Gastrointestinal:	☐ reflux	☐ diarrhea	☐ vomiting	
Genitourinary:	☐ trouble urinating	☐ discharge	☐ ulcer	
Integumentary:	☐ skin cancer	☐ acne	☐ rosacea	☐ eczema
Musculoskeletal:	☐ arthritis	☐ gout	☐ joint pain	☐ muscle pain
Neurological:	☐ numbness	☐ memory loss	☐ dizziness	☐ stroke
Psychiatric:	☐ anxiety	☐ depression		
Endocrine:	☐ diabetes	☐ hypothyroidism	☐ Grave's disease	
Hematologic:	☐ high cholesterol	☐ anemia	☐ bleeding disorder	
Immunologic:	☐ allergies	☐ immune disorder		

Do any of your blood relatives have the following conditions: ☐Adopted ☐ Unknown

Blindness:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment:	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Heart disease	☐ No	☐ Yes	If yes:	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

SOCIAL HISTORY

Do you currently smoke?	☐ No	☐ Yes	How much?	
Have you ever smoked?	☐ No	☐ Yes	When did you quit?	
Do you drive?	☐ No	☐ Yes		
Are you pregnant?	☐ No	☐ Yes	Expected Due Date?	
Are you nursing?	☐ No	☐ Yes		
Are you working?	☐ No	☐ Yes	☐ Retired	Occupation:
Do you drink?	☐ No	☐ Yes		