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:				