

Ocular & Medical History Questionnaire

(Please print)

Ocular Medical History

Do you wear glasses: Yes No

Do you wear contact lenses: Yes No

Past/Present Ocular History: Check Yes or No and provide a start/stop date for all conditions. Document any ocular surgeries with related dates.

Condition	Yes √	No √	Which eye? (Right, Left or Both)	Start date	Stop date or ongoing	Name of Surgery (if applicable)	Date of Surgery (if applicable)
<i>Example:</i> Cataract	√		Right	05/--/2004	2/22/2008	Removal of cataract	2/22/2008
Cataract							
Glaucoma (increased pressure in the eye)							
Myopia (Near-sightedness-LASIK surgery)							
Hyperopia (Far-sightedness)							
Lazy Eye (Amblyopia)							
Macular Degeneration (Vision loss in the center of the visual field)							
Dry Eye							
Retinal Detachment							
Progressive Retinal Disease (Vision loss due to deterioration of the retina)							
Allergic Conjunctivitis (redness in the white part of the eye; itchy, red eyes)							

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Follicular Conjunctivitis (yellowy, fat material in the white part of the eye)							
Blepharitis (swelling, redness, and soreness of the eyelids)							
Eye Herpetic Infection							
Other Specify below:							

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Non-Ocular Medical History

Past/Present Non-Ocular History: Check Yes or No and provide a start/stop date for all conditions. Please include:

- Current and past conditions
- Long term and chronic conditions
- Surgeries with related dates

Body Systems (examples)	Specify Condition	Yes √	No √	Location (if applicable; specify Right or Left)	Start date	Stop date or ongoing	Name of Surgery (if applicable)	Date of Surgery (if applicable)
<i>Example: <u>Reproductive</u></i>	<i>Postmenopausal</i>	√			02/--/2005	<i>Ongoing</i>		
<u>Allergies</u> (pollen, mold, animals, food, medication)								
<u>Cardiovascular</u> (high blood pressure, heart attack, CHF)								
<u>Ear, Nose, Mouth & Throat</u>								
<u>Respiratory</u> (asthma, COPD)								
<u>Endocrine</u> (Insulin or non-insulin dependent diabetes)								
<u>Gastrointestinal</u> (ulcer, GERD, Irritable Bowel Syndrome)								
<u>Genitourinary/Kidneys/Liver</u> (urinary tract infections, prostate enlargement)								
<u>Reproductive</u> (tubal ligation, postmenopausal, vasectomy, hysterectomy and reason for surgery)								

Approved by Alpha IRB March 31, 2011



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Body Systems (examples)	Specify Condition	Yes √	No √	Location (if applicable; specify Right or Left as indicated)	Start date	Stop date	Name of Surgery (if applicable)	Date of Surgery (if applicable)
<u>Musculoskeletal</u> (osteoarthritis) Specify location as indicated								
<u>Neurological</u> (stroke, seizures, headaches, migraines)								
<u>Psychiatric</u> (depression, anxiety, panic attacks, bipolar disorder)								
<u>Skin</u> (eczema, psoriasis, rosacea)								
<u>Hematologic/Lymphatic</u> (blood disorders, leukemia, high cholesterol)								
<u>Immunologic</u> (lupus, chronic fatigue syndrome, gout, rheumatoid arthritis)								
<u>Other</u> (specify in condition column)								

Comments: _____

Please list all ocular and non-ocular medications on the next pages



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Ocular Medications

Please record any prior or current ocular medications (include “as needed” and over-the-counter medications) taken within the last 30 days.

O Check here if NONE

Name Of Medication	Specify Eye (Right, Left, or Both)	Dose	Units	How often do you take it?	Start Date	Stop Date or ongoing	Why do you take this medication?
<i>Example: Visine-A</i>	<i>Both</i>	<i>1</i>	<i>Drop</i>	<i>Once daily</i>	<i>10/--/1996</i>	<i>ongoing</i>	<i>Allergic conjunctivitis</i>



