Thomas C. Teather, M.D., F.A.A.P.O.S.
General and Pediatric Ophthalmology
LASIK PRK

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date _____ Chart # _____

Referring Physician (if any) _____ Today's Date _____

LIST ANY MAJOR ILLNESSES OR SURGERIES (please check below)

	YES	NO		YES	NO
EYES			OTHER MEDICAL		
Cataract			Diabetes		
Glaucoma			Cancer		
Macular degeneration			Heart Disease		
Retinal detachment			High blood pressure		
Lazy eye			Asthma		
Laser treatment			Chronic bronchitis or emphysema		
Other eye conditions: _____			Stroke		
			Arthritis		
			Thyroid disease		
			Other medical conditions: _____		

Describe any surgeries/hospitalizations within the past year:

_____

_____

_____

List ALL medications except eye medications here:

_____

_____

_____

_____

List eye medications, including EYEDROPS/OINTMENTS here:

_____

_____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medications: _____

Physician's Signature _____ Date _____

For Office Use Only — DO NOT WRITE Below This Line

History Reviewed & Updated			History Reviewed & Updated		
Date	Signature	Changes	Date	Signature	Changes

Name _____ Chart # _____

Please check yes or no. DO NOT LEAVE ANYTHING BLANK.

REVIEW OF SYSTEMS	Yes	No		Yes	No
General			**Heart/Vessels**		
Fever			Chest Pain		
Weight loss			Palpitations		
Eyes			**Lungs**		
Loss of vision			Cough		
Blurred vision			Shortness of Breath		
Loss of side vision			**Skin**		
Dry eyes			Rashes		
Sandy/gritty eyes			Itching		
Eye discharge			**Digestive**		
Chronic eye infection			Change in bowel habits		
Red eyes			Vomiting		
Itching/burning eyes			**Urinary**		
Eye pain/soreness			Change in urinary frequency		
Foreign body in eye			Blood in urine		
Excess tearing			**Musculoskeletal**		
Light sensitivity			Joint pain		
Stye			Pain on chewing		
Floaters			**Neurologic**		
Flashes			Headache		
Ear/Nose/Throat			Tingling		
Dry mouth			**Emotional**		
Sinus congestion			Depressed mood		
			Anxiety		

FAMILY HISTORY (please check below) M = mother F = father S = sibling GP - grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other (describe)			

SOCIAL HISTORY

Are you at risk for AIDS or other sexually transmitted diseases? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No

Occupation: _____

Former occupation (if retired): _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you drink alcohol? ❑ No ❑ occasional ❑ 1 per day ❑ 2-3 per day ❑ 4+ per day

Do you smoke? ❑ No ❑ occasional ❑ 1/2 pack/day ❑ 1 pack/day ❑ 1+ pack/day

Education: ❑ High School ❑ College degree ❑ Post Graduate degree

Do you drive? ❑ Yes ❑ No

Remarks: _____