



MEDICAL HISTORY QUESTIONNAIRE
Boulder Eye Surgeons
Donald J. Keller, MD Brian E. Nichols, MD PhD

Name: _____ **Date:** ____/____/____

Date of birth: ____/____/____ Last eye exam: _____

Are you currently wearing glasses? Yes No Currently wearing contacts? Yes No

Please check any of the following that you are having problems with:

EYES:	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Tired Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Distorted Vision		
	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Loss of Side Vision	<input type="checkbox"/> Dryness	<input type="checkbox"/> Itching		
	<input type="checkbox"/> Burning	<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/> Excessive Tearing	<input type="checkbox"/> Redness		
	<input type="checkbox"/> Discharge	<input type="checkbox"/> Sandy or Gritty Feeling	<input type="checkbox"/> Glare	<input type="checkbox"/> Light Sensitivity		
	<input type="checkbox"/> Eye Pain/Soreness	<input type="checkbox"/> Changes in Vision	<input type="checkbox"/> Chronic Infection of Eye or Eyelid			
ENT:	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Chronic Cough		
	<input type="checkbox"/> Dry Throat or Mouth					
OTHER:	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Heart	<input type="checkbox"/> Blood Vessels	
	<input type="checkbox"/> Lungs	<input type="checkbox"/> Breathing	<input type="checkbox"/> Stomach	<input type="checkbox"/> Bladder	<input type="checkbox"/> Kidneys	<input type="checkbox"/> Genitals
	<input type="checkbox"/> Muscles	<input type="checkbox"/> Joints	<input type="checkbox"/> Skin	<input type="checkbox"/> Blood	<input type="checkbox"/> Lymph Nodes	
	<input type="checkbox"/> Swelling	<input type="checkbox"/> Allergies				

Please explain any of the checked items: _____

Have you had misaligned (crossed) eyes, lazy eye, drooping eyelids or prominent eyes? Yes No

With or without your current glasses or contacts, do you have any of the following?:

Visual difficulty when driving? Yes No Visual difficulty when reading? Yes No
 Problems with night vision? Yes No How old are your current glasses? _____

EYE HISTORY

- None Glasses-years worn:____ Contacts-years worn:____ Cataract
 Glaucoma Macular degeneration Retinal detachment Trauma
 Eye misalignment Amblyopia

Other not listed above: _____

Eye Surgeries: _____

MEDICAL HISTORY

- None Cancer Arthritis Diabetes Steroid use Rheumatoid arthritis
 Thyroid Migraine Asthma Stroke Heart attack High blood pressure
 High cholesterol Neurofibromatosis Juvenile Rheumatoid Arthritis
 Down's Prematurity (birth weeks):____(birth weight):_____

Other illnesses or surgeries not included above: _____

ORAL MEDICATIONS (PILLS AND EYE DROPS)

None Medications: _____

ALLERGIES

None Allergic to: _____

CONTINUED ON BACK

Physician signature: _____ Date: ____/____/____



MEDICAL HISTORY QUESTIONNAIRE (continued)
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SOCIAL HISTORY

Do you smoke? Yes No If YES, how many packs a day? _____
 Do you drink alcohol? Yes No If YES, how often? _____
 Do you drink caffeine? Yes No If YES, how often? _____

FAMILY HISTORY

Does anyone in your family have any of the following conditions?

DISEASE		Relationship to Patient
Eye Misalignment	<input type="radio"/> Yes <input type="radio"/> No	_____
Lazy Eye	<input type="radio"/> Yes <input type="radio"/> No	_____
Blindness	<input type="radio"/> Yes <input type="radio"/> No	_____
Cataract	<input type="radio"/> Yes <input type="radio"/> No	_____
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	_____
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	_____
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	_____
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	_____
Cancer	<input type="radio"/> Yes <input type="radio"/> No	_____
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	_____
Heart Attack	<input type="radio"/> Yes <input type="radio"/> No	_____
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	_____
Lupus	<input type="radio"/> Yes <input type="radio"/> No	_____
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	_____
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	_____
Sjogren Syndrome	<input type="radio"/> Yes <input type="radio"/> No	_____
Stroke	<input type="radio"/> Yes <input type="radio"/> No	_____
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	_____
Other: _____	<input type="radio"/> Yes <input type="radio"/> No	_____