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Champlain Ophthalmology

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CATARACT & IMPLANT SURGERY
CORNEA & EXTERNAL DISEASE
GLAUCOMA SURGERY & MANAGEMENT
OCULAR IMMUNOLOGY & UVEITIS

Name: ___________________________________ **Date of Birth:** ____________ **Today's Date:** ____________

If new patient, how did you hear about our practice? ____

MEDICAL HISTORY QUESTIONNAIRE

What is the purpose of your visit today? ____

List **Medical Conditions**, surgeries, or injuries with dates:

____
____
____
____
____

List all **Medications** (include eye drops):

____
____
____
____
____

Medication Allergies: ____

Family Medical History (if yes, please include relationship):

Blindness	___________	Heart Disease	__________
Glaucoma	___________	Arthritis	______________
Macular Degeneration	______	Auto-immune	__________
Retina	___________	Cancer	______________
Cataract	___________	Diabetes	______________
Other	________________________________		

Social History: Occupation: ________________

Hobbies: ______________________________

Alcohol: YES NO Smoking: YES NO

Drugs: YES NO

Have you fallen in the past year? YES NO

Flu vaccine this year? YES NO

Pneumococcal vaccine (age>65)? YES NO

Do you wear glasses? (Indicate if they are for reading, distance, or both): _______________________________

Do you wear contacts? (indicate what type and how often): ____

Have you had LASIK, PRK, or other refractive surgery? (Indicate where and when): _______________________

Review of Systems: Please circle if you have any issues with any of the following:

Eyes:			**Other:**	
	Loss of Vision	Blurred Vision	Diabetes	Thyroid issues
	Double Vision	Fluctuating Vision	Environmental Allergies	Heart Disease
	Dryness	Tearing	Runny nose/Sore throat	Hypertension
	Sandy/Gritty	Red eye	Breathing/Asthma	Rapid Heart Rate
	Crusty lashes	Discharge	Migraines	Sleep Apnea
	Eye pain	Itching	Muscle/Joint Pain	Stomach Issues
	Lazy Eye	Strabismus	Hearing difficulties	Dry Mouth
	Floaters	Flashes	Stroke/Mental Status	Dizziness
	Lid swelling	Glare at night	Herpes	HIV