



Beri Eye Care Associates, PC

Medical History Questionnaire

Name _____ Date _____

DOB _____

Date of last eye exam _____ Place of last eye exam _____

List any medications you *currently* take (prescription and over-the-counter):

Do you have any *allergies* to any medications? _____ YES _____ NO

If yes, list the medications: _____

List all *major illnesses* or *injuries*:

_____ Arthritis	_____ Diabetes	_____ Recent Injury/Fall
_____ Asthma	_____ Emphysema	_____ Stroke
_____ Atrial Fibrillation	_____ Hypertension	_____ Other _____
_____ Cancer	_____ Heart Attack	
_____ Thyroid disease	_____ Kidney Failure/Dialysis	

List any *surgeries, radiation, or chemotherapy* you have had and the date:

_____ Angioplasty	/ /	_____ Coronary Bypass	/ /
_____ Appendectomy	/ /	_____ Hernia Repair	/ /
_____ Cataract Extraction	/ /	_____ Radiation / Chemotherapy	/ /
_____ Cholecystectomy	/ /	_____ Other _____	/ /

Do you *currently* have any problems in the following areas? If "Yes", please provide information.

EYES	YES	NO	Explanation of Problem
Loss of vision			
Blurred Vision			
Fluctuating vision			
Distorted vision (halos)			
Flashes of light/floaters			
Loss of side vision/peripheral			
Double vision			
Dryness			
Mucous discharge/pus			
Redness			
Sandy or gritty feeling			
Itching/burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes/headache			
Crossed eyes, lazy eye			
Drooping eyelid			

