Today's Date: _____ Acct # _____

Oklahoma EYE SURGEONS
Steven R. Sarkisian, Jr., MD

Medical History Questionnaire

Patient Name: _____ **Date of Birth:** _____
Referring Eye Doctor: _____ **Date of last exam:** _____
Reason for today's visit: _____
Preferred Pharmacy Name: _____ **Pharmacy Number:** _____
Pharmacy Address: _____

Past Ocular History: (*Please circle all that apply)*

Cataracts	Diabetic Retinopathy	Glaucoma	Macular Degeneration
Dry Eyes	Retinal Detachment	Optic Neuritis	Keratoconus
Myopic	Astigmatism	Presbyopia	Hyperopia
Iritis	Amblyopia	Aphakic	Pseudophakic

Do you wear contacts? Circle ***YES*** or ***NO***

Please list ALL past Ocular Surgeries including dates (you may provide a list): *(Cataract Surgery, Glaucoma Surgery/Laser, Lasik, PRK, Corneal Transplant, Retinal Surgery/Laser/Injections, Strabismus Surgery, etc.)*

_____

_____

Please list all other surgeries within the past year:

_____

_____

Social History: *(Please circle which applies to you)*

Smoking: *Current everyday smoker* *Current someday smoker* *Former smoker* *Never smoker*

Alcohol Use: ***YES*** ***or*** ***NO***
If yes, how often? _____

Drug Use: ***YES*** ***or*** ***NO***
If yes, what and how often? _____

Personal Health History: *(Please circle all that apply)*

Diabetes (Type I)	Rheumatoid Arthritis	Hypertension	Grave's Disease
Diabetes (Type II)	Sjogrens	Multiple Sclerosis	Hypothyroidism
Lung Disease	Anemia	COPD	High Cholesterol
Liver Disease	Arthritis	Rosacea	Asthma
Fibromyalgia	Kidney Disease	Cancer	Stroke
Heart Disease	Multiple Sclerosis	Parkinson's	Dementia

Congestive Heart Failure Other:_____

Family History: *(Please circle all that apply)*

Glaucoma	Amblyopia	Cataracts	Macular Degeneration
Diabetes	Stroke	Cancer	Blindness
Hypertension	High Cholesterol	Kidney Disease	Retinal Disease
Arthritis	Heart Disease	Strabismus	Family History Unknown

Review of Systems (Current Symptoms): *(Please check all that apply)*

Eyes
- ❑ Pain
- ❑ Double Vision
- ❑ Redness
- ❑ Itching
- ❑ Excessive Watering
- ❑ Flashes of Light
- ❑ Floaters
- ❑ Cloudy/Foggy Vision
- ❑ Dryness

Respiratory
- ❑ Coughing
- ❑ Congestion
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Sleep Apnea

If so, do you sleep with a CPAP?
- ❑ Yes
- ❑ No

Hematologic/Blood
- ❑ Bruises Easily
- ❑ Prolonged Bleeding
- ❑ Heavy Aspirin Use
- ❑ Anemia

Ear, Nose and Throat
- ❑ Hard of Hearing
- ❑ Ringing in Ears
- ❑ Vertigo
- ❑ Sore Throat
- ❑ Post-nasal Drip
- ❑ Mouth Sores

Gastrointestinal
- ❑ Heartburn
- ❑ Vomiting
- ❑ Nausea
- ❑ Jaundice
- ❑ GERD
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loss of Appetite

Musculoskeletal
- ❑ Joint Pain
- ❑ Stiffness of Joints
- ❑ Swelling of Joints
- ❑ Muscle Pain
- ❑ Back Pain

Cardiovascular
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Irregular Heartbeat
- ❑ Difficulty Lying Flat

Genitourinary
- ❑ Pain / Difficulty
- ❑ Blood in Urine
- ❑ Kidney Stones
- ❑ STD
- ❑ Bladder Problems
- ❑ Incontinence

Neurological
- ❑ Seizures
- ❑ Headaches
- ❑ Migraines
- ❑ Weakness
- ❑ Paralysis
- ❑ Numbness
- ❑ Tremors

Endocrine
- ❑ Increased Thirst
- ❑ Increased Hunger
- ❑ Increased Urination
- ❑ Increased Sweating
- ❑ Fingernail Changes

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Mood Swings
- ❑ Difficulty Sleeping

Skin
- ❑ Rash
- ❑ Sores
- ❑ Lesions
- ❑ Hives
- ❑ Eczema

Immunologic
- ❑ Hives
- ❑ Itching
- ❑ Runny Nose
- ❑ Sinus Pressure

Constitutional
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Night Sweats
- ❑ Recent Trauma

Please list ALL **eye drops** you are currently using**:**

_____

_____

Please list ALL **medications** you are currently taking including vitamins, supplements and if you get steroid injections, OR you may provide a list.

_____

_____

_____

Do you have any known **drug allergies**? If so, please list below. (Including eye drops)

Drug: _____ Reaction: _____ mild / moderate / severe
Drug: _____ Reaction: _____ mild / moderate / severe
Drug: _____ Reaction: _____ mild / moderate / severe

Signature: _____ Date: _____