Aurora EYE CLINIC

HEALTH HISTORY

Patient Name _____ Date _____

Primary Care Physician _____ Referring Physician _____

Please indicate if you currently or have had any of the following medical conditions:

- ☐ Asthma
- ☐ Brain tumor
- ☐ Cancer *(type/location)*_____
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Heart attack
- ☐ Head Injuries
- ☐ Headache
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Prostate disease
- ☐ Rheumatoid disease
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Currently pregnant or nursing
- ☐ Other:_____

Please indicate if you currently have past and/or present eye conditions:

- ☐ Blepharitis
- ☐ Diabetic retinopathy
- ☐ Glaucoma
- ☐ Lazy eye
- ☐ Cataract
- ☐ Double vision
- ☐ Iritis
- ☐ Macular degeneration
- ☐ Corneal transplant
- ☐ Eye injury
- ☐ LASIK/PRK/RK
- ☐ Retinal detachment

Please list any past eye surgeries or laser treatments:

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

Do you have allergies, reactions to medications or problems with anesthesia? ☐ Yes ☐ No
If yes, please describe:

_____

_____

_____

Social History

Alcohol	☐ None	☐ Rarely	☐ Occasionally
Tobacco *(cigarettes, cigars, chew)*	☐ Never	☐ Former (year quit:_____)	☐ Current (years used: ____)
Recreational drug use	☐ Never	☐ Former	☐ Current

Family History

	Father	Mother	Sibling(s)
Blindness	☐	☐	☐
Diabetes	☐	☐	☐
Glaucoma	☐	☐	☐
Macular degeneration	☐	☐	☐
Muscle disorders of the eye	☐	☐	☐
Retinal detachment	☐	☐	☐

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CATARACT SURGERY QUESTIONNAIRE

Please respond to the following questions to help our doctors best serve your visual needs.

1. Do you wear contact lenses?		YES	NO	
	If YES, are they:	SOFT CONTACT LENSES	RIGID GAS PERMEABLE LENSES	
	If YES, are they for:	DISTANCE ONLY	MULTIFOCAL	MONOVISION (one eye for distance, one eye for reading)
2. Have you had previous eye surgery?		YES	NO	
3. Have you had trauma to either eye?		YES	NO	
4. Do you (or have you previously) taken a medication for your prostate, kidneys, bladder, or urination? Flomax (tamsulosin), Proscar (finasteride), Hytrin (terazosin), prazosin, alfuzosin, doxazosin		YES	NO	
5. Are you claustrophobic?		YES	NO	
6. Can you lay flat on your back comfortably for 1 hour?		YES	NO	
7. Do you have tremors of your head, hands, or feet?		YES	NO	
8. Have you had any of the following in the past 6 months? Any surgery, heart attack, stroke, cardiac procedure, hospitalization, major health change		YES	NO	
9. Do you take blood thinners? Aspirin, Coumadin (warfarin), Plavix (clopidogrel), Eliquis (apixaban), Pradaxa (dabigatran), Heparin		YES	NO	