Bruening Eye Specialists
Medical History Questionnaire
101 Tower Road Suite 300 ~ Dakota Dunes, SD 57049 5500 Sergeant Road Suite 200 ~ Sioux City, IA 51106

Today's Date:_____ **Name**:_____ **DOB**:_____

Primary Care Physician _____ **Endocrinologist** _____

Neurologist_____ **Pulmonologist**_____ **Cardiologist**_____

What is the main reason for your visit today?
_____
_____

Do you have any of these eye symptoms?
□ Blurred distance vision □ Glare, halos around lights
□ Blurred reading vision □ Itching or burning eyes
□ Constant double vision □ Eye mattering or tearing
□ Flashing lights or floaters □ Foreign body sensation
□ Red Eyes □ Dry Eye □ Eye Pain

Which *eye medications* do you currently take?
□ None □ Artificial Tears

Medication Name	Amount	How many time/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Please list any *eye surgeries* you have had:
□ None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Do you have any allergies to any medications?
□ None known □ Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	

List current medication(s) below or provide a copy:
□ None □ Aspirin on a daily basis

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Please list *other* surgeries you have had:
□ None

Type of surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had any of these conditions?
□ None
□ Stroke □ Dizziness □ Arthritis □ Allergies
□ High blood pressure □ Heart disease
□ Diabetes □ AIDS, HIV □ Lung diseases
□ Cancer □ Anemia □ Thyroid disease
□ Headaches □ Other:
_____

Have you ever had any of these *eye* problems?
□ Cataract □ Glaucoma □ Macular Degeneration
□ Retinal detachment □ Iritis/uveitis □ Lazy eye
□ Serious eye injury □ Wore eye patch as a child

Are you allergic to LATEX? Yes / No
Do you have a history of MRSA? Yes / No

Do you use? □ Tobacco □ Alcohol

Have any family members had any *eye* diseases?
(father, mother, sister, brother, grandparents)
□ Cataract □ Glaucoma □ Macular Degeneration
□ Diabetic eye disease or diabetes □ Poor vision
□ Retinal detachment □ Iritis/uveitis □ Blindness
□ Crossed eyes □ Other:

Review of Systems: *Do you currently have any of the following problems?*

	Y	N
Chronic fever, unexpected wt. loss/gain…	□	□
Ear/nose/throat (hearing loss, sinus, throat)	□	□
Heart (chest pain, irregular heart beat)	□	□
Respiratory (shortness of breath, coughing)	□	□
Gastrointestinal (heartburn, diarrhea, vomit.)	□	□
Urine (pain, blood in urine)	□	□
Skin (rashes, excessive dryness)	□	□
Musculoskeletal (muscle aches, joint pain)	□	□
Neurologic (numbness, weakness, headache)	□	□
Psychiatric (depression, anxiety)	□	□