South Bay Ophthalmology, Inc.

Edward J. Saub, M.D.
Eye Physician and Surgeon

Optical Shop

Medical History Questionnaire

LAST NAME _____ **MI** _____ **FIRST NAME** _____

DATE _____ **AGE** _____ **WHO REFERRED YOU**? _____

1. What is your **OCCUPATION**? _____

2. What is the **MAIN REASON** for your visit? _____

3. Please list all known **ALLERGIES** to medications or LATEX: ❒ None ❒ See attached list

MEDICATION	REACTION
_____	_____
_____	_____

4. Please list any **EYE PROBLEMS** you have or have had: ❒ None ❒ See attached list
(For example: glaucoma, macular degeneration, cataract, lazy eye, strabismus, eye trauma, prism glasses, etc….)

_____

_____

5. Please list any **EYE SURGERY** you have had in the past: ❒ None ❒ See attached list
(For example: glaucoma, cataract, retina, laser surgery, eyelid surgery, injections, etc….)

_____ _____

6. Please list all your **EYE DROPS**: ❒ None ❒ See attached list

NAME OF EYE DROP	WHICH EYE(S)	HOW OFTEN
_____	_____	_____
_____	_____	_____

7. Please list any **MEDICAL PROBLEMS** you have or have had: ❒ None ❒ See attached list
(For example: high blood pressure, diabetes, heart disease, arthritis, etc.)

_____

_____

8. Please list any **SURGERIES** you have had: ❒ None ❒ See attached list

_____ _____

_____ _____

9. Please list all your **MEDICATIONS AND SUPPLEMENTS**:

NAME OF MEDICATION	FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____

❒ None
❒ See attached list

10. **Current Immunizations**

	Yes	No
Flu	☐	☐
Covid-19	☐	☐
Covid-19 Booster	☐	☐
Pneumonia	☐	☐
Shingles	☐	☐

11. Does or did anyone in your **FAMILY** ever have any of the following?

Glaucoma?	___ Yes	___No	Who? _____
Macular Degeneration?	___ Yes	___No	Who? _____
Blindness?	___ Yes	___No	Who? _____
Diabetes?	___ Yes	___No	Who? _____

12. What is your **SMOKING** history?

Current Every Day Smoker	*Current Some Day Smoker*	*Former Smoker, Quit:* _____	*Never Smoked*
❒	❒	❒	❒

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13. Describe your **ALCOHOL** consumption:

Never	*Rare*	*On Occasion*	*1 per day:*	*2 per day:*	*3 or more per day:*
❒	❒	❒	❒ wine ❒ beer ❒ cocktail	❒ wine ❒ beer ❒ cocktail	❒ wine ❒ beer ❒ cocktail

14. Circle your **RELATIONSHIP** status? *Single* *Married* *Domestic Partner* *Widowed* *Divorced*

15. What is your **PREFERRED LANGUAGE**? _____

16. Of the following choices**, WHICH BEST DESCRIBES YOU**? Please check one.

American Indian/Alaska Native	*Asian*	*Black/African American*	*Native Hawaiian/Pacific Islander*	*Hispanic/Latino*	*All Others*
❒	❒	❒	❒	❒	❒

17. Do you wear **GLASSES**? ___ Yes ___No

18. Do you wear **CONTACT LENSES**? ___ Yes ___No ***How often***? _____ ***Monovision***? Y / N **Near Eye:** R / L

What brand? _____

What power? Right: _____ Left: _____ ***What base curve***? Right: _____ Left: _____

19. Please indicate whether or not you **CURRENTLY HAVE** any of the following symptoms or conditions listed:

Eyes	Y	N		**Respiratory**	Y	N		**Blood/Lymph**	Y	N
Previous Surgery				Cough				Easy Bruising		
Contact Lens				Congestion				Gums Bleed Easily		
Pain				Wheezing				Prolonged Bleeding		
Double Vision				Asthma				Heavy Aspirin Use		
Glaucoma				Tuberculosis				Autoimmune Disorder		
Cataracts				Sinusitis				Lymphoma or Leukemia		
Macular Degeneration				History of COVID-19 infection						
Dry Eyes										
Flashes				**Gastrointestinal**				**Musculoskeletal**		
Floaters				Heartburn				Stiffness		
				Nausea/Vomiting				Arthritis		
Ear, Nose, Throat				Jaundice/Hepatitis				Joint Pain/Swelling		
Hard of Hearing				Dental Problems				Low Back Pain		
Ringing in Ears				Crohn's Disease or Colitis						
Vertigo								**Skin**		
Sleep Apnea				**Genito-Urinary**				Rash/Sores		
Excessive Dry Mouth				Pain/Difficulty				Lesions		
Snoring				Blood in Urine				Hives/Eczema		
Cardiovascular				History of Kidney Stones						
Chest Pain				History of STDs				**Neurological**		
Dizziness				Kidney Disease				Seizures		
Fainting Spells								Weakness/Paralysis		
Shortness of Breath				**Psychiatric**				Numbness		
Irregular Heart Beat				Anxiety				Tremors		
Difficulty Lying Flat				Depression				Headache or Migraine		
Raynaud's Syndrome				Mood Swings				Multiple Sclerosis		
Stroke				Difficulty Sleeping						
				Endocrine				**Immunologic**		
Constitutional				Increased Thirst				Hives		
Fatigue/Weakness				Increased Hunger				Itching		
Fever				Increased Urination				Runny Nose		
Weight Gain/Loss				Increased Sweating				Sinus Pressure		
Night Sweats				Fingernail Changes				HIV		