Anca D. Pacuraru, D.O.,F.A.O.C.O.
Board Certified Ophthalmologist

Fellowship Trained Glaucoma Specialist
Ophthalmic Surgery • Cataract Surgery
General Ophthalmology

Medical History Questionnaire

Name: ____ Today's Date: _______________

Current Age: ___________________ Birth Date: ____/___/_____

REVIEW OF SYSTEMS

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

EXPLANATION OF PROBLEM

Eyes	**NO**	**YES**	
Loss of Vision			
Loss of side vision	☐	☐	____________________
Distorted vision, halos, or glare	☐	☐	____________________
Night vision problems	☐	☐	____________________
Fluctuating vision	☐	☐	____________________
Flashing lights or Floaters	☐	☐	____________________
Dark spots or veils over vision	☐	☐	____________________
Eye pain or soreness	☐	☐	____________________
Light sensitivity	☐	☐	____________________
Double vision	☐	☐	____________________
Crossing or drifting of eyes	☐	☐	____________________
Redness or Discharge	☐	☐	____________________
Sandy or gritty feeling	☐	☐	____________________
Dryness	☐	☐	____________________
Itching or Burning	☐	☐	____________________
Excess tearing/watering	☐	☐	____________________
Tired eyes	☐	☐	____________________
Other	☐	☐	____________________

PH: (325) 701-9885
TF: (855) 813-1446
FAX: (325) 701-9884

2959 Buffalo Gap Road
Abilene, TX 79605
www.abilenepremiereyecare.com

Fever, Weight loss/gain or fatigue	☐	☐	______________
Skin	☐	☐	______________
Ear, nose, mouth, throat	☐	☐	______________
Cardiovascular (heart/blood vessels)	☐	☐	______________
Respiratory (lungs/breathing)	☐	☐	______________
Gastrointestinal (stomach)	☐	☐	______________
Genito-urinary	☐	☐	______________
Males	☐	☐	______________
Females	☐	☐	______________
Musculoskeletal (bones/joints/muscles)	☐	☐	______________
Neurological (headaches)	☐	☐	______________
Psychiatric	☐	☐	______________
Endocrine (diabetic/thyroid)	☐	☐	______________
Bleeding tendency	☐	☐	______________
Seasonal allergies, hay fever, recent cold	☐	☐	______________

Other symptoms not listed above ______________________________

____

PAST HISTORY

Please circle any allergies that you have:

Local anesthetics	Aspirin	Flourescein Dye (Iodine/Betadine)
Penicillin	Codeine or narcotics	Latex
Sulfa or other antibiotics	Shellfish	Other ______________

Current Eye Medications (dosage if known)

______________ ______________

______________ ______________

Current medications, vitamins, or herbal supplements (dosage if known)

______________ ______________

______________ ______________

______________ ______________

PH: (325) 701-9885
TF: (855) 813-1446
FAX: (325) 701-9884

Anca D. Pacuraru

2959 Buffalo Gap Road
Abilene, TX 79605
www.abilenepremiereyecare.com

OCULAR HISTORY

Date of your last exam ______________________________ Doctor ________________________

Please circle any condition that applies to you:

Lazy eye	Cataract	Retinal detachment/tear
Glaucoma	Crossed eyes	Macular degeneration/pucker/hole
Serious eye injury	Lid problems	Diabetic retinopathy

Other ____

Eye surgery including laser surgery (If yes list dates, eye and surgeon) ____________________________

____

MEDICAL HISTORY

Please circle any condition that applies to you:

Asthma	Emphysema	High blood pressure
Cancer	Stroke/TIA	Anemia
Thyroid disease	Arthritis/rheumatoid	HIV
High cholesterol	Hepatitis AJB/C	Kidney disease/dialysis
Migraines	Sinus infection	Low blood pressure
Sleep apnea	Trauma	Pregnant

Heart disease: angina/heart attack/irregular heart beat/atrial fibrillation/stents/open heart surgery artificial valve

Other____

____

If answer to Diabetes is No, skip this section

No	**Yes**
☐	☐ Insulin required, # of years_____
☐	☐ No Insulin required
☐	☐ Type I (Childhood onset)
☐	☐ Type II (Adult onset)

Age at onset: _________

Total# of years, diabetic _______

Last Hemoglobin A1C (less than 7.0%) _______

If answer to Glaucoma is No, skip this section

Age at Diagnosis

Highest intraocular pressures (if known) _____________

Previous glaucoma drops used (if known) ____________

____

Any allergies to glaucoma medications ______________

SURGERIES: ____

____

FAMILY HISTORY

Any one in your family with any of the following: If yes, please indicate the family member.

Lazy eye ______________________________

Cataract______________________________

Glaucoma______________________________

Macular degeneration______________________

Retinal detachment______________________

Arthritis______________________________

Cancer ______________________________

Diabetes______________________________

Heart disease__________________________

High blood pressure______________________

Kidney disease__________________________

Stroke________________________________

Blindness______________________________

Other ________________________________

SOCIAL HISTORY

	Yes	**No**	
Do you drink alcohol?	☐	☐	
Do you smoke?	☐	☐	Drinks per day _______ per week.__________________
Have you quit smoking?	☐	☐	Packs per day ________# of years __________________
Do you use drugs?	☐	☐	How many years ago _________

PH: (325) 701-9885
TF: (855) 813-1446
FAX: (325) 701-9884

Anca D. Pacuraru

2959 Buffalo Gap Road
Abilene, TX 79605
www.abilenepremiereyecare.com