OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

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OphthalmologySA.com

GLAUCOMA QUESTIONNAIRE

Who referred you to my practice? _____

When were you diagnosed with glaucoma or a glaucoma concern? _____

What was/were the circumstance(s) surrounding that diagnosis?

☐ High eye pressure ☐ Abnormal optic nerve ☐ Visual field abnormality

Do you have a family history of glaucoma? ☐ Yes ☐ No
If so, please describe _____

Have your ever suffered ocular trauma? ☐ Yes ☐ No
If so, please describe _____

Have you had any adverse reactions to glaucoma medications ☐ Yes ☐ No
If so, please describe _____

Have you had any glaucoma lasers or surgeries? ☐ Yes ☐ No
If so, please describe _____

Have you had any other eye lasers or surgeries? ☐ Yes ☐ No
If so, please describe _____

Have you had any neurological conditions or surgeries? ☐ Yes ☐ No
If so, please describe _____

Do you have any of the following conditions?

☐ Diabetes mellitus ☐ High blood pressure ☐ Low blood pressure ☐ Migraines
☐ Sleep apnea syndrome ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Kidney stones
☐ Vasospasm

Have you required use of any of the following medications?

☐ Steroids ☐ Antihistamines ☐ Urinary flow medications

Do you participate in any of the following activities?

☐ Yoga ☐ Inversion table positioning ☐ Wind instrument playing

Name: _____ Date: _____