Neuro-Ophthalmology Questionnaire

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Name:_____ Age:____ Sex: **M** **F** Race:_____ Today's Date: ____/____/____

Date of Birth: ___/___/_____ Marital Status: _____ Occupation: _____

Please list <u>all</u> medical problems for which you take medicine:

1) _____ 4) _____ 7) _____
2) _____ 5) _____ 8) _____
3) _____ 6) _____ 9) _____

Please list all prior major surgeries and dates (including eye surgery):

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Please list all current daily prescription medications & eye drops; including aspirin:

	Medication name	*Dose (mg)*	*How often do you take it?*
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			

Have you been on any of the following medications in the last one year? (circle any that apply)

Amiodarone (Cordarone) Ethambutol Isoniazid **Viagra/Cialis/Levitra** **Digoxin**/Lanoxin Vincristine

Cyclosporine **Plaquenil** (Hydroxychloroquine) **Dilantin** (Phenytoin) Accutane (Isotrentoin) Linezolid

List all medications you are allergic to:_____

Please list all prior eye problems:_____

_____

Have you ever been prescribed prism glasses? **Yes** **No** If yes, when_____By Whom?_____

Have you ever smoked? **Y** **N** How many years? _____ # of packs/day:____ QUIT? **Y** **N** When?_____

Ever consumed alcohol? **Y** **N** How many years? ____ # drinks/week:____ QUIT? **Y** **N** When?_____

Any medical problems that run in your family? If so, please describe illness and which family members were affected: _____

_____

Have you ever been diagnosed or treated for any of the following conditions?

			Date:				Date:
High Blood Pressure	**Yes**	**No**		**Neuropathy**	**Yes**	**No**	
Diabetes	**Yes**	**No**		**Cancer (type)_____**	**Yes**	**No**	
Migraine Headache	**Yes**	**No**		**Meningitis**	**Yes**	**No**	
Brain Tumor	**Yes**	**No**		**Syphilis**	**Yes**	**No**	
Epilepsy/Seizures	**Yes**	**No**		**Sarcoidosis**	**Yes**	**No**	
Hypothyroidism	**Yes**	**No**		**Lyme disease**	**Yes**	**No**	
Hyperthyroidism	**Yes**	**No**		**Cat-scratch disease**	**Yes**	**No**	
Myasthenia Gravis	**Yes**	**No**		**Myopathy (muscle disease)**	**Yes**	**No**	
Grave's Disease	**Yes**	**No**		**Multiple Sclerosis (MS)**	**Yes**	**No**	
Stroke	**Yes**	**No**		**Alcoholism**	**Yes**	**No**	
Parkinson's Disease	**Yes**	**No**		**Lupus (SLE)**	**Yes**	**No**	
Horner's Syndrome	**Yes**	**No**		**Bleeding or clotting disorder**	**Yes**	**No**	
Bell's Palsy	**Yes**	**No**		**Hydrocephalus (water on the brain)**	**Yes**	**No**	
Amblyopia or Lazy Eye	**Yes**	**No**		**Coronary Artery Disease**	**Yes**	**No**	
Retinal Detachment	**Yes**	**No**		**HIV or AIDS**	**Yes**	**No**	
Glaucoma	**Yes**	**No**		**Herpes**	**Yes**	**No**	
Optic Neuritis	**Yes**	**No**		**Temporal or Giant Cell Arteritis**	**Yes**	**No**	
Head Trauma	**Yes**	**No**		**Pseudotumor Cerebri**	**Yes**	**No**	
Trigeminal Neuralgia	**Yes**	**No**		**Blepharospasm**	**Yes**	**No**	
Hemifacial Spasm	**Yes**	**No**		**Peptic Ulcer Disease/Gastritis**	**Yes**	**No**	
Osteoporosis	**Yes**	**No**		**Scleroderma**	**Yes**	**No**	
Vertigo	**Yes**	**No**		**Fibromyalgia**	**Yes**	**No**	
Tuberculosis (TB)	**Yes**	**No**		**Temporomandibular Jt Synd (TMJ)**	**Yes**	**No**	
Asthma	**Yes**	**No**		**Kidney Stones**	**Yes**	**No**	
Seasonal Allergies	**Yes**	**No**		**Arrhythmia**	**Yes**	**No**	
High Cholesterol	**Yes**	**No**		**Cluster headache**	**Yes**	**No**	
Menstrual abnormalities	**Yes**	**No**		**Shingles**	**Yes**	**No**	
Sinusitis	**Yes**	**No**		**TIA**	**Yes**	**No**	
Arthritis	**Yes**	**No**		**Pacemaker implant**	**Yes**	**No**	
Vitamin B12 Deficiency	**Yes**	**No**		**Defibrillator implant**	**Yes**	**No**	
Liver Disease	**Yes**	**No**		**Anemia**	**Yes**	**No**	
Kidney Disease	**Yes**	**No**		**Pituitary tumor**	**Yes**	**No**	
Toxoplasmosis	**Yes**	**No**		**Macular degeneration**	**Yes**	**No**	

Review of Systems:

Have you recently had?

If Yes, provide any additional details (i.e. when it began, if intermittent: how long it lasts, how often it occurs, etc.) along the right side of the page

				DETAILS:
1.	Numbness	**Yes**	**No**	_____
2.	Tingling	**Yes**	**No**	_____
3.	Fatigue/Lethargy	**Yes**	**No**	_____
4.	Muscle weakness	**Yes**	**No**	_____
5.	Muscle aches	**Yes**	**No**	_____
6.	Balance difficulty	**Yes**	**No**	_____
7.	Loss of coordination	**Yes**	**No**	_____
8.	Ringing in the ears (tinnitus)	**Yes**	**No**	_____
9.	Scalp tenderness/soreness to the touch	**Yes**	**No**	_____
10.	Fever	**Yes**	**No**	_____
11.	Neck pain	**Yes**	**No**	_____
12.	Difficulty swallowing	**Yes**	**No**	_____
13.	Difficulty speaking	**Yes**	**No**	_____
14.	Pain in the jaw with chewing	**Yes**	**No**	_____
15.	Weight loss	**Yes**	**No**	(if yes, how much? _____)
16.	Depression	**Yes**	**No**	_____
17.	Poor color vision	**Yes**	**No**	_____
18.	Anxiety/Nervousness	**Yes**	**No**	_____
19.	Blind spots in your vision	**Yes**	**No**	_____
20.	Eye pain or discomfort	**Yes**	**No**	_____
21.	Sinus congestion	**Yes**	**No**	_____
22.	Chronic cough	**Yes**	**No**	_____

23. Double vision: **Yes** **No** (If no, skip to question #24)

a. Does the double vision go away when:

The right eye is closed? **Yes** **No**_____

The left eye is closed? **Yes** **No**_____

b. Are the objects double (circle all that apply) ***Side-by side*** ***One on top of the other***

24. Drooping of one or both eyelids **Yes** **No**_____

25. Flashing lights in your vision **Yes** **No**_____

26. Floaters **Yes** **No**_____

27. Facial pain **Yes** **No**_____

28. Headache **Yes** (circle all that apply below) **No** (If no, skip to question #29)

Throbbing/pulsating ***Squeezing/pressure-like feeling*** ***Aching sensation*** ***Sharp***

29. Nausea or vomiting **Yes** **No**_____

30. Loss of consciousness **Yes** **No**_____

31. Dry mouth/throat **Yes** **No**_____

32. Decreased hearing **Yes** **No**_____

33. Shortness of breath/Wheezing **Yes** **No**_____

34. Chest pain **Yes** **No**_____

35. Muscle pain (out of the ordinary) **Yes** **No**_____

36. Joint pain (out of the ordinary) **Yes** **No**_____

37. Frequent urination **Yes** **No**_____

38. Dizziness **Yes** (circle all that apply below) **No** (If no, skip to question #39)

Spinning sensation ***Lightheadedness*** ***Triggered by change in body posture/change in head position***

39. Blurred vision **Yes** (circle all that apply below) **No** (If no, skip to question #40)

Right eye ***Left eye*** ***Both eyes*** ***Fluctuating*** ***Constant*** ***At distance*** ***While Reading***

40. Temporary loss of vision **Yes** (circle type below) **No**

Right eye ***Left eye*** ***Both eyes***

How often has this happened?_____ ***How long did it last?***_____