MEDICAL HISTORY QUESTIONNAIRE

NAME_____ DOB_____

Allergies to medications: YES NO If yes, please list_____

Past ocular history and surgeries:

*Cataracts: RT LT Both Dates_____

*Glaucoma: RT LT Both Dates_____

*Laser/Lasik: RT LT Both Dates_____

*Macula: RT LT Both Dates_____

*Retina: RT LT Both Dates_____

Current Eye Medications:

1._____

2._____

3._____

Past medical history and surgeries:

( ) Arthritis ( ) Diabetes ( ) High Blood Pressure ( ) Heart Attack ( ) Thyroid ( ) Other

List Surgeries: _____

_____

Current Medications:

1._____

2._____

3._____

4._____

5._____

6._____

Family History: ( ) Diabetes ( ) Stroke ( ) Blindness ( ) Macular Degeneration ( ) Arthritis ( ) Cancer ( ) TB ( ) Cataract ( ) Retinal Disease ( ) Heart Disease ( ) Glaucoma ( ) High Blood Pressure

Social History: **Smoke**: YES NO **Drink Alcohol**: YES NO **Drugs**: YES NO

Please circle that apply:

Respiratory: Cough Congestion Wheezing Asthma
Blood/Lymph nodes: Easy Bruising Gums Bleed Easily Prolonged Bleeding Heavy Aspirin Use
Gastrointestinal: Hearburn Nausea/Vomiting Hepatitis
Muscles: Stiffness Arthritis Joint Pain
Ear, Nose, Throat: Hard of Hearing Ringing in Ears Vertigo
Genito-Urinary: Pain Blood in Urine Kidney Stone
Skin: Rash/Sores Lesions Hives/Eczema
Cardiovascular: Chest Pain Dizziness Fainting Spells Shortness of Breath Irregular Heart Beat
Psychiatric: Anxiety/Depression Mood Swings Difficulty Sleeping
Neurological: Seizures Weakness/Paralysis Numbness Tremors