

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ BIRTHDATE _____ AGE _____

MEDICATIONS:

PAST EYE SURGERIES:

Do you currently have any problems in the following areas?	N	Y	DESCRIBE
RECENT ILLNESS			
EAR NOSE THROAT (hearing, sinus)			
HEART (chest pain, heart rhythm)			
RESPIRATORY (asthma, emphysema)			
KIDNEY/URINARY (infections, stones)			
BONES (arthritis, fractures)			
SKIN (rashes, lesions, cancer)			
NEUROLOGICAL (strokes, seizures, dizziness)			
EMOTIONAL (anxiety, depression)			
ENDOCRINE (thyroid, weight changes)			
BLOOD (anemia, bleeding, bruising)			
ALLERGIES (medication, tape, environmental, dye, fluorescein, latex)			

HAVE YOU BEEN IN THE HOSPITAL RECENTLY? IF SO WHAT FOR?

ARE YOU DIABETIC? _____ HOW LONG? _____ UNDER CONTROL? _____

DO YOU HAVE HIGH BLOOD PRESSURE? _____ CANCER? _____ TYPE? _____

OTHER MEDICAL PROBLEMS _____

HAVE YOU HAD ANY MAJOR SURGERIES IN YOUR LIFE? _____ WHAT TYPE? _____

FAMILY HISTORY: GLAUCOMA _____ DIABETES _____ RETINAL DETACHMENT _____ MACULAR DEGENERATION _____

WHO HAS IT: _____

WHAT IS YOUR OCCUPATION? _____

DO YOU DRIVE? _____ DO YOU SMOKE? _____ DO YOU DRINK ALCOHOL? _____

SIGNATURE: _____ DATE: _____