MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date of Birth _____

Please list all **major illnesses** or **major injuries** you have had (diabetes, heart attack, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had the following surgical procedures?

	Yes	No	If YES, please explain:
Carotid Artery	☐	☐	_____
Heart	☐	☐	_____
Pacemaker implanted	☐	☐	_____
Defibrillator implanted	☐	☐	_____
Lung	☐	☐	_____
Spine	☐	☐	_____
Brain	☐	☐	_____
Cancer	☐	☐	_____

Please list any **eye** surgeries you have had:

_____

_____

Have you ever had a serious **eye** injury? _____ If so, please explain: _____

_____

Please list all medications (including eye medications) you are taking (prescription & over-the-counter):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? _____ If so, please list: _____

_____

Are you allergic to latex? _____

See Back

We are concerned about your **general health** as problems elsewhere in the body may affect the health of your eyes and vision. Do you ***currently*** have any problems in the following areas?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear, nose, mouth, or throat problems	☐	☐	_____
Breathing problems, emphysema, bronchitis, asthma	☐	☐	_____
High blood pressure, heart disease	☐	☐	_____
Rashes, excessive dry skin	☐	☐	_____
Stomach problems, abdominal pain, heartburn, diarrhea	☐	☐	_____
Genital, kidney, bladder, prostate problems, jaundice, etc.	☐	☐	_____
Arthritis, muscle aches, joint pain, swollen joints	☐	☐	_____
Diabetes, thyroid problems	☐	☐	_____
Allergies/Immunologic, itching, hives, lupus, etc.	☐	☐	_____
Depression, anxiety	☐	☐	_____
Neurologic (multiple sclerosis, Parkinson's, Alzheimer's)	☐	☐	_____
Blood/lymph problems, cholesterolemia, anemia, etc.	☐	☐	_____

Family History (please circle any that apply and their relationship to you)

Glaucoma

Macular Degeneration

Retinal Disorders

Lazy Eye/Cross-eye

Blindness

Diabetes

Social History:

Occupation: _____

Do you use tobacco (including smokeless tobacco)? Yes ☐ No ☐

Do you use alcohol? Yes ☐ No ☐