MEDICAL HISTORY QUESTIONNAIRE

Name_____

Date of Birth _____ Date of last eye exam _____

Have you ever had any of the following eye procedures:

__LASIK __Cataract Surgery Laser Treatment For: __Glaucoma __Retina

Have you ever had any eye trauma? _____ If so, please explain: _____

_____

Have <u>you or any of your blood relatives</u> had any of the following?

Diabetes: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

If you are Diabetic, how long ago were you diagnosed?_____

Glaucoma: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Macular Degeneration: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Retinal Detachment: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Blindness: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Multiple Sclerosis: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Cardiovascular Disease: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Hypertension: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Thyroid Disease: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Autoimmune Disease: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Asthma: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

COPD: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Alzheimer's: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Stroke: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Transient Ischemic Attack __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Parkinson's: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Bell's Palsy: __Yes __No **IF YES**: __Myself __Father __Mother __Sibling __Grandparent

Cancer: __Yes __No **IF YES**:

Cancer Type_____ __Myself __Father __Mother __Sibling __Grandparent

Cancer Type_____ __Myself __Father __Mother __Sibling __Grandparent

Are you pregnant? __Yes __No If Yes, what is your expected due date?_____

PLEASE COMPLETE AND SIGN REVERSE SIDE

SOCIAL HISTORY

Do you smoke? __Yes __No Have you ever smoked? __Yes __No

Do you drink alcohol? __Yes __No __Occasional __1/day __2/day __3/day __Over 3/day

SURGERIES: List any medical surgeries you have had and when:

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS: List current medications (prescription, over the counter, vitamins, and eyedrops)

Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? __Yes __No If Yes, please list medications:

_____

_____

Any other pertinent information _____

_____

_____

_____ _____

Patient Signature **Date**