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Medical History Questionnaire

Name: ____ DOB: ____/____/_____

Primary Care Physician: ____________________________ Referring Physician: ____________________

Pharmacy: _____________________________ Location: _____________________________

Social History

Smoking: ○ Current everyday Smoker ○ Someday Smoker ○ Former Smoker ○ Never

Alcohol Use: ○ Yes / How much and how often? __________________________ ○ No

Drug Use: ○ Yes / Type and how often? _________________________________ ○ No

Allergies

__________________________ Mild/Moderate/Severe ______________________ Mild/Moderate/Severe

__________________________ Mild/Moderate/Severe ______________________ Mild/Moderate/Severe

Family History

○ Blindness ○ Macular Degeneration ○ Retinal Disease ○ Diabetes

○ Cataracts ○ Glaucoma ○ High Blood Pressure ○ Stroke

○ Other: ____

Systemic Illnesses:

○ Diabetes ○ High Blood Pressure ○ Rheumatoid Arthritis ○ Lupus ○ AIDS /HIV

○ Headaches ○ High Cholesterol ○ Arthritis ○ Herpes Simplex ○ Hepatitis

○ Hyperthyroid ○ Hypothyroid ○ Multiple Sclerosis ○ COPD ○ Heart Failure

○ Other: ____

Current Medications (Please List)

Medication	Dosage

General Surgeries/ Operations (Please List)

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Ocular History

- ◯ Cataracts
- ◯ Diabetic Retinopathy
- ◯ Iritis
- ◯ Retinal Detachment
- ◯ Glaucoma
- ◯ Macular Degeneration
- ◯ Dry Eyes
- ◯ Optic Neuritis
- ◯ Sjogrens
- ◯ Graves Disease
- ◯ Herpes
- ◯ Keratoconus
- ◯ Other: ______________________________

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Ocular Surgeries

- ◯ No Prior Surgery
- ◯ Yag Laser
- ◯ Trabeculectomy
- ◯ LASIK/PRK/RK
- ◯ Cataract Surgery
- ◯ Retinal Laser
- ◯ Vitrectomy
- ◯ Blepharoplasty
- ◯ Glaucoma Drainage Tube
- ◯ Glaucoma Laser
- ◯ Foreign Body Removal
- ◯ Corneal Transplant

Other: ______________________________

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Current Eye Medications

Medication	Which Eye & How Often