MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________ Date of Birth: _____________ Today's Date: ____________

Please identify which eye surgery you have had, if any: (Please circle yes or no)

Cataract surgery yes/no :Right eye date/doctor ____________ Left eye date/doctor ____________

Glaucoma surgery yes/no :Right eye date/doctor ____________ Left eye date/doctor ____________

Retinal surgery yes/no :Right eye date/doctor ____________ Left eye date/doctor ____________

Vision correction surgery yes/no :Right eye date/doctor ____________ Left eye date/doctor ____________

Other eye surgery __________ :Right eye date/doctor ____________ Left eye date/doctor ____________

Other prior eye conditions or concerns: ☐ None

____

Eye Drops or Ointments that you use now: List drug name, which eye, and how ofter: ☐ None

____

____

Primary Physician: (local preferred) ________________________ Physician's city/state _______________

Current medication list (including dosage): ☐ None ☐ List Attached

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Allergies: Please list any prior drug/substance allergy: ☐ No known drug allergies ☐ List Attached

	Drug/substance name:	Type of reaction:	Severity: (circle)
allergy to:	___________________________	___________________________	mild / moderate / severe
allergy to:	___________________________	___________________________	mild / moderate / severe
allergy to:	___________________________	___________________________	mild / moderate / severe
allergy to:	___________________________	___________________________	mild / moderate / severe
allergy to:	___________________________	___________________________	mild / moderate / severe

Please list other prior surgeries and the year (approximate if needed): ☐ None ☐ List Attached

____

____

Have you been diagnosed with any of the following?:

☐ High Blood Pressure ☐ Heart Disease ☐ Arthritis ☐ Asthma/COPD ☐ Cancer/type? __________________

☐ High Cholesterol ☐ Stroke ☐ Thyroid - High or Low (please circle one) ☐ Diabetes/type? ________________

Other medical history not listed above: ☐ None

____

____

Smoking: ☐ every day smoker ☐ social smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often? ________________________________

Drug Use: ☐ Yes ☐ No If yes, how much and how often? ________________________________