MEDICAL HISTORY QUESTIONNAIRE

NAME_____ DOB_____

Allergies to medications: YES NO If yes please list _____

Past ocular history and surgeries

*Cataracts RT LT Both Dates:_____

*Glaucoma RT LT Both Dates:_____

*Laser/Lasek RT LT Dates:_____

*Macula RT LT Both Dates:_____

*Retina: RT LT Both Dates:_____

Current eye medications

1._____

2._____

3._____

Current Medication

1._____

2._____

3._____

4._____

5._____

6._____

Past medical history and surgeries

( ) Arthritis ( ) Diabetes ( )High Blood Pressure ( ) Heart Attack ( ) Thyroid

( ) Other_____

List Surgeries _____

_____

_____

Family history: ( ) Diabetes ( ) Stroke ( ) Blindness ( ) Macular Degeneration ( ) Arthritis ( ) Cancer ( ) TB .
. ( ) Cataract ( ) Retinal Disease ( ) Heart Disease ( ) Glaucoma ( ) High Blood Pressure
. ( ) Other_____

Social History: *Smoke*: YES NO *Drink Alcohol:* YES NO *Drugs*: YES NO

Review of systems- Please cirlce

Respiratory			*Blood/ Lymphnodes*			*Gastrointestinal*			*Muscles*		
Cough	Yes	No	Easy Bruising	Yes	No	Hearburn	Yes	No	Stiffness	Yes	No
Congestion	Yes	No	Gums Bleed Easily	Yes	No	Nausea/Vomiting	Yes	No	Arthritis	Yes	No
Wheezing	Yes	No	Prolonged Bleeding	Yes	No	Hepatitis	Yes	No	Joint Pain	Yes	No
Asthma	Yes	No	Heavy Aspirin Use	Yes	No						

Ear, Nose, And Throat			*Genito-Urinary*			*Skin*			*Cardiovascular*		
Hard of Hearing	Yes	No	Pain	Yes	No	Rash/Sores	Yes	No	Chest Pain	Yes	No
Ringing in Ears	Yes	No	Blood in Urine	Yes	No	Lesions	Yes	No	Dizziness	Yes	No
Vertigo	Yes	No	Kidney Stone	Yes	No	Hives/Eczema	Yes	No	Fainting Spells	Yes	No
									Shortness of Breath	Yes	No
									Irregular Heart Beat	Yes	No

Psychiatric			*Neurological*		
Anxiety/Depression	Yes	No	Seizures	Yes	No
Mood Swings	Yes	No	Weakness/Paralysis	Yes	No
Difficulty Sleeping	Yes	No	Numbness	Yes	No
			Tremors	Yes	No

Interested In Lasek: Yes No

Interested in Contact Lenses: Yes No

Interested in non Surgical Correction Yes No