Medical History Questionnaire

please, fill in all areas OR list them as N/A

NAME:____ TODAY'S DATE:_________________

DATE OF BIRTH: ________________

Name of your **medical doctor (primary care physician)** and **city**: ____

If you were **referred** by a doctor, please list **name** and **city**:____

If you are **diabetic**, please list the **name** and **city** of the doctor who takes care of you:______________________________

If you have a **cardiologist**, please list the **name** and **city** of the doctor:____

MEDICAL CONDITIONS: (CHECK ALL THAT APPLY)

○ **DIABETES (year diagnosed_______)** ○ **HIGH BLOOD PRESSURE** ○ **HEART DISEASE** ○ **HIGH CHOLESTEROL** ○ **IRREGULAR HEART RHYTHM** ○ **HISTORY OF STROKE** ○ **HISTORY OF HEART ATTACK**	○ **KIDNEY FAILURE/DIALYSIS** ○ **HEPATITIS** ○ **ARTHRITIS** ○ **CANCER (location_________)** ○ **THYROID DISEASE** ○ **DEPRESSION** ○ **OBSTRUCTIVE SLEEP APNEA** ○ **ASTHMA**	○ **COPD** ○ **PROSTATE PROBLEMS, & ARE TAKING OR HAVE TAKEN MEDICATIONS FOR THIS IN THE PAST** ○ **Other________________** ○ **Immunizations up to date?**

List **Any Surgeries** You've Had In The Past (**anywhere on the body**) :

____

____

____

Did you have problems with anesthesia? (circle) **Yes / No** What problems**?**_________________________________

Do you have a pacemaker? (circle) **Yes / No** **Do you have a Defibrillator ?** (circle) **Yes / No**

Please, list any any **EYE DISEASE/EYE INJURIES/EYE SURGERIES** you've had in the past: (including dates, if possible)

____

____

____

Family History:

Please, circle any **family history** that you are aware of (living or deceased) for the following conditions :

DISEASE/CONDITION

GLAUCOMA ---- Mother Father Sibling Grandparent Family

MACULAR DEGENERATION---- Mother Father Sibling Grandparent Family

DIABETES---- Mother Father Sibling Grandparent Family

HEART DISEASE---- Mother Father Sibling Grandparent Family

HIGH BLOOD PRESSURE---- Mother Father Sibling Grandparent Family

PROBLEMS WITH ANESTHESIA---- Mother Father Sibling Grandparent Family

List Drug/Medicine Allergies : **Reactions** :

___________________________ → ___________________________

___________________________ → ___________________________

___________________________ → ___________________________

___________________________ → ___________________________

___________________________ → ___________________________

If 'NO KNOWN ALLERGIES',
Circle → ***NKA***

Do you have a **LATEX** sensitivity or allergy : (circle) Yes / No If so, What kind of reaction?_____________

Are you currently using any Eye Drops? Including any artificial tears, please list below:

____

Current Medications :
(Including oral contraceptives, aspririn, over the counter medications and home remedies)
List **Medications** and **Dosage** :

____
____
____
____
____

Social History :
This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you are more comfortable.

Do you drive? (circle) Yes / No
Do you smoke? (circle) Yes / No **How many per day?** ___________
Do you use smokeless tobacco? (circle) Yes / No
Do you drink alcohol? (circle) Yes / No **How often?** (circle) Rarely / Socially / Frequently
Do you use illegal drugs? (circle) Yes / No
Have you ever been exposed to or infected with the following : (circle all that apply)
Gonorrhea Hepatitis HIV Syphilis MRSA

Misc :
Are you Pregnant? (circle) Yes / No
Do you wear glasses? (circle) Yes / No
Do you wear contact lenses? (Circle) Yes / No

Height? __________**Weight?** ___________

What is your PREFERRED PHARMACY, and in what CITY?____

Is there any other information that we did not cover, that you would like us to know to better serve you?
____
____
____