

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)

<input type="radio"/> DIABETES (year diagnosed_____)	<input type="radio"/> KIDNEY FAILURE/DIALYSIS	<input type="radio"/> COPD
<input type="radio"/> HIGH BLOOD PRESSURE	<input type="radio"/> HEPATITIS	<input type="radio"/> PROSTATE PROBLEMS, & ARE TAKING OR HAVE TAKEN MEDICATIONS FOR THIS IN THE PAST
<input type="radio"/> HEART DISEASE	<input type="radio"/> ARTHRITIS	<input type="radio"/> Other_____
<input type="radio"/> HIGH CHOLESTEROL	<input type="radio"/> CANCER (location_____)	<input type="radio"/> Immunizations up to date?
<input type="radio"/> IRREGULAR HEART RHYTHM	<input type="radio"/> THYROID DISEASE	
<input type="radio"/> HISTORY OF STROKE	<input type="radio"/> DEPRESSION	
<input type="radio"/> HISTORY OF HEART ATTACK	<input type="radio"/> OBSTRUCTIVE SLEEP APNEA	
	<input type="radio"/> ASTHMA	

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, aspirin, 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?
