MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ______________________________ DATE: _______________

DOB: _________________ DATE OF LAST EYE EXAM: ____________________

Are you being treated for or have you ever been treated for the following conditions?

If YES, please provide additional information in the space provided.

HEALTH HISTORY	YES	NO	DETAILS
DIABETES (If yes, are you on insulin?)			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
RESPIRATORY (asthma, COPD, emphysema)			
SLEEP APNEA			
HEART CONDITION			
STROKE			
CANCER (if yes, please indicate type)			
RECENT SURGERY (type & date)			
EYE HISTORY	**YES**	**NO**	**DETAILS**
CATARACT SURGERY			
GLAUCOMA			
OTHER EYE SURGERY			

Allergies:

Do you have any allergies to medications? ❑ Yes ❑ No

If YES, list medications____

Do you have any other allergies we should be aware of? ❑ Yes ❑ No

If YES, describe ____

Family History:

Has any member of your family (mother, father, grandparent, sibling) had any of these diseases?

❑ Macular Degeneration (AMD) ❑ Retinal Detachment ❑ Glaucoma ❑ Diabetic Retinopathy
❑ Blindness ❑ Cataract ❑ Myopia (nearsightedness) ❑ Amblyopia (lazy eye)
❑ Diabetes ❑ Hypertension ❑ Heart Disease ❑ Stroke ❑ Cancer ❑ Thyroid Disease
❑ Arthritis ❑ Other heritable disease: ______________________________________

MEDICAL HISTORY QUESTIONNAIRE

(continued)

PATIENT NAME: ______________________________ DATE: ____________________________

Social History:

Does your vision limit any activities of daily living (such as driving, reading, sports, work, etc.)?

❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No

Do you drive? ❑ Yes ❑ Daylight Only ❑ No

Do you drink alcohol? ❑ Yes ❑ No If YES, how much? ________________

Do you smoke? ❑ Yes ❑ No ❑ Quit If YES, how much? _______________ How long? __________

Medications:

****If you provided the receptionist with a current list of your medications, you DO NOT need to complete the information below.****

Please list each of the medications that you take.

Medication	Dose	How Often

Don't forget to include:

- ❑ Eye Drops
- ❑ Vitamins
- ❑ Herbal Supplements

(Especially Vitamin E or Fish Oil)

Are you on any blood thinners?

- ❑ Aspirin
- ❑ Coumadin
- ❑ Plavix
- ❑ Pradaxa
- ❑ Other: ___________