Medical History Questionnaire : Please Fill Out

Name: _____
Last First
Middle

Age: _____ Date of Birth: _____

Previous Surgeries and Dates: _____

Allergies: _____

Medications Including Dosage: _____

Current Active Medical Problems: _____

Do you have (circle yes or no):

Yes No Diabetes If yes, do you take insulin? Yes No

Yes No Kidney Disease

Yes No High Blood Pressure

Yes No Heart Condition

Yes No Strokes or Neurological Problems

Yes No Have you ever had a reaction to anesthetics?

Yes No Any other active or inactive medical problems?

Retina Vitreous CENTER PC