Medical History Questionnaire: Please Fill Out

Patient Name: _____ DOB: _____ Today's Date: _____

Which of the following conditions are you currently being treated for or have been treated for in the past (please check):

- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart Murmur
- ☐ Angina
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heartburn (reflux)
- ☐ Anemia
- ☐ Blood disorder
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Lung problems
- ☐ Cough
- ☐ Sinus problems
- ☐ Seasonal allergies
- ☐ Tonsillitis
- ☐ Ear problems
- ☐ Hearing Aids
- ☐ Psychiatric care
- ☐ Eye disorder
- ☐ Glaucoma
- ☐ Seizures
- ☐ Stroke
- ☐ Headaches
- ☐ Migraines
- ☐ Neurological problems
- ☐ Depression
- ☐ Anxiety
- ☐ Swollen ankles
- ☐ Kidney
- ☐ Urinary problems
- ☐ Liver problems
- ☐ Arthritis
- ☐ Cancer
- ☐ Ulcers
- ☐ Colitis
- ☐ Crohn's
- ☐ Thyroid disorder
- ☐ Other: _____

Please list your past ocular treatments: (Procedure, Date, Eye(s))

- ☐ Cataract Extraction Date? Which Eye(s)? _____
- ☐ Laser Date? Which Eye(s)? _____
- ☐ Injections Date? Which Eye(s)? _____
- ☐ Glaucoma Stent Date? Which Eye(s)? _____
- ☐ Lasik/Vision Correction Surgery Date? Which Eye(s)? _____
- ☐ Other Date? Which Eye(s)? _____

Please list your past ocular surgeries: (Procedure, Date, Eye(s))

- ☐ Retinal Detachment Date? Which Eye(s)? _____
- ☐ Macular Hole Date? Which Eye(s)? _____
- ☐ Epiretinal Membrane Date? Which Eye(s)?
- ☐ Other Date? Which Eye(s)? _____

Please list your other surgeries: (Procedure, Date)

_____

_____

_____

Do you have or have you ever had:

HIV / Aids?	☐ Yes	☐ No	Other Active Infectious Diseases: _____
Hepatitis A, B, or C?	☐ Yes	☐ No	_____
MRSA?	☐ Yes	☐ No	_____
Ocular Herpes?	☐ Yes	☐ No	

Social and Preventive History:

Have you had a pneumonia vaccine? ☐ Yes ☐ No If yes, when? _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how often? _____ If no, have you in the past? ☐ Yes ☐ No

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Occasional

Any current recreational drug use? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

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PLEASE CONTINUE FILLING OUT ON REVERSE ☞

Medical History Questionnaire (Continued): Please Fill Out

Family History:

☐ Heart disease	Relation: _____	☐ Glaucoma	Relation: _____
☐ High cholesterol	Relation: _____	☐ Macular Degeneration	Relation: _____
☐ High blood pressure	Relation: _____	☐ Diabetic Retinopathy	Relation: _____
☐ Blood disorders	Relation: _____	☐ Vein Occlusions	Relation: _____
☐ Diabetes	Relation: _____	☐ Retinal Detachment / Tears	Relation: _____
☐ Cancer	Relation: _____	☐ Myopia	Relation: _____
☐ Thyroid disorders	Relation: _____	☐ Blindness	Relation: _____

☐ Other: _____

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