MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date:_____

What is you major vision problem:_____

Do you currently use any eye drops?___Yes___No
If yes, please list_____

Have you had any eye surgery?___Yes___No
If yes, please check: LASIK__ Glaucoma Surgery__ Laser Surgery__ Cataract Surgery___
Eyelid Surgery__ Retinal Surgery__ Other (list)_____

Do you have diabetes? ___Yes ___No
If yes, how long? ____years Is it controlled? ____Yes ____No

Do you have: Glaucoma __Yes __No Macular Degeneration __Yes __No

Has any immediate member (parents, siblings, children) of your family had:
Glaucoma __Yes __No Macular Degeneration __Yes __No Diabetes __Yes __No

Do you smoke? __Yes __No __Ex Smoker Do you drink alcohol? __Yes __No

Do you have allergies to any medications? __Yes __No
If yes, please list_____

Have you ever taken Flomax/ Tamsulosin (prostate medicine) __Yes __No

List all major illness or injury:_____

List any medications you currently take:_____

_____

Do you currently have any of the following: (Please check if yes)

Memory loss___	Dementia___	Alzheimer's___
High Blood Pressure___	High Cholesterol___	Stroke___
Heart attack___	Rheumatoid Arthritis___	Heart failure___
Shortness of Breath___	Asthma___	Emphysema___
Cardiac Arrhythmia___	Low Blood Pressure___	Anemia___
Angina___	Arthritis___	Syncope___
Kidney Failure___	Colitis___	Hepatitis___
Jaundice___	Osteoporosis___	Cancer___
Stomach Ulcer___	Migraine___	Sinusitis___
Seizures___	Brain tumor___	Bronchitis___
Concussion___	Depression___	Psychiatric Disorder___
Hyperthyroid___	Hearing loss___	Hypothyroid___