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)

○ **DIABETES (year diagnosed_____)**	○ **KIDNEY FAILURE/DIALYSIS**	○ **COPD**
○ **HIGH BLOOD PRESSURE**	○ **HEPATITIS**	○ **PROSTATE PROBLEMS, & ARE TAKING OR HAVE TAKEN MEDICATIONS FOR THIS IN THE PAST**
○ **HEART DISEASE**	○ **ATHRITIS**	
○ **HIGH CHOLESTEROL**	○ **CANCER (location_____)**	
○ **IRREGULAR HEART RHYTHM**	○ **THYROID DISEASE**	
○ **HISTORY OF STROKE**	○ **DEPRESSION**	○ **Other_____**
○ **HISTORY OF HEART ATTACK**	○ **OBSTRUCTIVE SLEEP APNEA**	○ **Immunizations up to date?**
	○ **ASHTMA**	

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, aspririn, 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?
_____
_____
_____