MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date _____ Birthdate _____

What brings you to the office today?_____

Do you currently have or have a history of the following eye conditions: Please Check if YES

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Corneal Dystrophy
- ☐ Dry Eyes
- ☐ Amblyopia
- ☐ Retinal detachment
- ☐ Macular Degeneration
- ☐ Uveitis
- ☐ Diabetic Retinopathy
- ☐ High CHOL/Lipids
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Autoimmune Disease
- ☐ Arthritis
- ☐ Hypertension

EYE SURGERY HISTORY: Do you have a history of any of these eye problems or procedures? Please Check if YES

- ☐Yes Cataract
- ☐Yes Corneal Transplant
- ☐Yes DSEK
- ☐Yes Retinal Procedure
- ☐Yes Strabismus Surgery
- ☐Yes Glaucoma Surgery
- ☐Yes LASIK/PRK/RK
- ☐Yes Other eye surgery not listed above (ie. eye trauma, etc.)_____

REVIEW OF FAMILY HISTORY (Please Check if YES for person indicated)

	Mother	Father	Sister	Brother
Cataracts	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐
Blindness	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐
Amblyopia	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐

CURRENT MEDICATIONS

List all other current Medications: _____
_____
_____

ALLERGIES:_____