Patient Name _____

MEDICAL HISTORY QUESTIONAIRE

EYE HISTORY

What eye problem(s) brought you to our office today?_____

_____

List any previous eye diseases, injuries or surgeries: _____

_____

List any eye drops you use (prescription or over-the-counter) _____

_____

GENERAL HEALTH

Please circle any health conditions:

High Blood Pressure Cholesterol Diabetes Neurological Thyroid Arthritis

Kidney Asthma Allergies Other: _____

List names of all medications used (we'll photocopy if you have a list) _____

_____

List any medications which cause allergies or sensitivity: _____

Previous surgeries: _____

SOCIAL HISTORY

Do you use nutritional supplements? (vitamins, etc) Yes No
Do you engage in regular exercise? Yes No
Do you drink alcohol? No 1 per day 2-3 per day 4+ per day
Do you smoke? No Occasional ½ - 1 pack per day over 1 pack per day
Do you use any other substances? Yes No
Hobbies/interests: _____

FAMILY HISTORY

Please list any eye conditions which run in your family (macular degeneration, etc.)

_____

Please list any health conditions which run in your family (diabetes, hypertension, etc.)

_____