Medical History Questionnaire V1.05

NAME:	**DATE:**
Please list any **MEDICAL CONDITION** for which you are **CURRENTLY BEING TREATED**, such as high blood pressure, high cholesterol, diabetes, heart disease, cancer, auto-immune disease, immune deficiency, organ transplant. →	☐ None
Please list any **MEDICAL CONDITIONS** for which you have been **TREATED IN THE PAST** such as the examples in the box above.. →	☐ None
Please list any **MEDICINES** you are currently taking. →	☐ None
Please list any **EYE PROBLEMS**, current or past. →	☐ None
Please list any **EYE DROPS** you are currently taking. →	☐ None
Please list any **PRIOR SURGERY**, including **EYE SURGERY**. →	☐ None
Please list any **DRUG OR FOOD ALLERGIES**. →	☐ None
Please list any **EYE DISEASES THAT RUN IN YOUR FAMILY** such as glaucoma, macular degeneration, cataract, diabetic retinopathy. →	☐ None
Please list any **HEALTH PROBLEMS THAT RUN IN YOUR FAMILY**, such as diabetes, cancer, auto-immune disease. →	☐ None

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? **PLEASE CIRCLE 'Y'OR 'N' FOR EACH QUESTION.**

Y N Chronic fever
Y N Diarrhea
Y N Fatigue
Y N Hearing loss
Y N Sinus problems
Y N Sore throat
Y N Chest pain

Y N Vomiting
Y N Headaches
Y N Blood in urine
Y N Skin rashes
Y N Dry skin
Y N Muscle aches
Y N Joint pain

Y N Irregular heart beat
Y N Shortness of breath
Y N Asthma
Y N Coughing
Y N Unexpected weight gain/loss
Y N Abdominal pain
Y N Urinary pain or discomfort

Y N Swollen joints
Y N Numbness
Y N Weakness
Y N Paralysis
Y N Anxiety
Y N Heartburn

Do you drink alcohol? →	
When did you smoke? Do you still smoke? →	
If employed, how many hours a week do you work? →	
Are you interested in finding out about refractive surgery (LASIK)? →	

The following signature indicates that this form has been reviewed by the physician:

Physician Signature: ______________________________________ Date:__________________