HEALTH QUESTIONAIRE

NAME:______________________________ DATE:______________________

REFERRED BY:______________________________

All Present Medications including Pills, Injections and Drops______________________________

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Allergies to Medications and Drops:______________________________

High Blood Pressure	No	Yes	Explain:
Diabetes	No	Yes	Explain:
Skin Problems	No	Yes	Explain:
Cancer	No	Yes	Explain:
Ear/Nose/Throat	No	Yes	Explain:
Heart Disease	No	Yes	Explain:
Stroke/Cardiovascular	No	Yes	Explain:
High Cholesterol	No	Yes	Explain:
Lung problems	No	Yes	Explain:
Liver Disease	No	Yes	Explain:
Kidney Disease	No	Yes	Explain:
Arthritis	No	Yes	Explain:
Headaches	No	Yes	Explain:
Blood Disorders	No	Yes	Explain:
Thyroid	No	Yes	Explain:
Gastrointestinal	No	Yes	Explain:
Neurological	No	Yes	Explain:
Multiple Sclerosis	No	Yes	Explain:
Tumors	No	Yes	Explain:
Pacemaker	No	Yes	Explain:
Other Illnesses	No	Yes	Explain:

Previous Eye Disease/Injury:______________________________

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Previous Eye Surgery/Laser Surgery and Date:______________________________

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Previous Operations:______________________________

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Family History:
Cataracts:______________________________
Glaucoma:______________________________
Macular Degeneration:______________________________
Blindness:______________________________
Other:______________________________

Alcohol: No Yes Tobacco: No Yes