NAME ____ **DATE OF BIRTH** ________/_______/________

AKA (Nickname) _______________________________ **TODAY'S DATE** ____________________________

What is the reason for your visit? ____

List ALL prescription medication you are currently using (including eye drops):

____ ____

____ ____

____ ____

Are you allergic to any medications? Yes / No

If yes, please list ____

What pharmacy do you use? ____

Have you ever had surgery on your eyes? Yes / No

If yes, please explain: ____

Personal medical history (please circle all that apply)

•Nervous system	•Endocrine/Thyroid	•Headaches/Migraines	•Ear/Nose/Throat
•Digestive	•Bladder/Intestinal	•Blood/Lymph	•Heart/High blood pressure
•Cholesterol	•Allergies	•Respiratory/Asthma	•Musculoskeletal
•Arthritis	•Diabetes	•Cancer, explain: __________________________________	
•Glaucoma	•Macular degeneration	•Other: ____	

Family medical history: (for example: diabetes, cancer, glaucoma, macular degeneration, etc) Yes/No

If yes, please explain ____

Social History:

•Do you smoke? Yes / No How much? ___________ Have you ever smoked? Yes / No How long?_________

• Do you drink alcohol daily? Yes / No How many drinks per day? _________

• What are your hobbies? ____

Patient signature: ____ Date: _________________

Name ______________________________________

MRN _______________________________________

OPHTHAMOLOGY HEALTH QUESTIONNAIRE