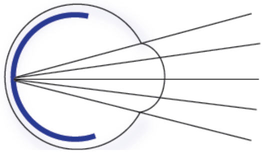

Patient's Name: ____

Patient's Account #: ___________ Patient's DOB: ___________

Health History Questionnaire

Please complete this form to the best of your knowledge.

Current Medications

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Prescription Drugs/ Non Prescription Drugs

Allergies to Medications (hives, itching, rash):

____
____
____
____
____
____
____

Do you wear prescription eye glasses or contact lenses? **YES** **NO**

Please bring your corrective eyewear with you to your appointment.

Health History

Please include eye and general health history.

Eye Diseases (glaucoma, macular degeneration, diabetic retinopathy, retinal tear/detachment, uveitis, iritis, trauma, and/or surgeries i.e. laser, lasik, cataract, cryo, scleral buckle):

Previous ____

____

Current ____

____

General Health and Surgeries (heart disease, high blood pressure, diabetes, thyroid, arthritis, cancer, etc.):

____
____
____

Social History: _____Alcohol _____Drugs _____Smoking _____Exercise

Do you have a history of blood transfusions? **YES** **NO**

Have you ever been tested for HIV and/or Hepatitis? **YES** **NO**

If yes, was your test positive or negative? ____

Patient Signature:________________________________ ***Date:*** ______________________