Medical History Questionnaire

Name:____ Date:____________________

Check all current medical conditions:

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ High Cholesterol ☐ Thyroid ☐ HIV/AIDS

List any **MAJOR** surgeries:

____

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Do **YOU** currently have or have you had any of the following:

☐ Cataracts ☐ Floaters ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment

List any **EYE** surgeries:

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List all medications or drugs, prescription and non-prescription, herbs, vitamins and home remedies that currently take:

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List any **MEDICATIONS** or **DRUGS** you are allergic to:

____

Does anyone in your immediate family (Mother, Father, Siblings, Grandparents) have the following:

☐ Glaucoma ☐ Macular Degeneration ☐ Blindness