KELLIS EYE & LASER CENTER
OPHTHALMOLOGY & OCULOPLASTIC SURGERY

Medical Questionnaire

Name: _____ DOB: _____

Pharmacy Name: _____ Phone #: _____

Health History			
Please answer the following questions:	Yes	No	If yes, please explain.
Do you take Flomax?			
Do you take Blood Thinners?			If yes, which one:
Do you take Plaquenil?			
Have you had LASIK or Refractive Surgery?			If yes, what type? When?
In your life, have you had any eye, face or head trauma?			
Have you ever had eyelid surgery?			If yes, when? Name of surgeon:
Do you presently get injectables in your face? (Botox, Xeomin, Dysport, Juvederm, Restylane)			Date of last injection:

Eye History

Has an Eye Doctor ever diagnosed or treated you for:

☐ Turned Eye/Lazy Eye/Ambylopia	☐ Glaucoma	☐ Retinal Pigmentosa
☐ Serious Eye Injury	☐ Macular Degeneration	☐ Vitreous Detachment
☐ Keratoconus	☐ Uveitis (Iritis)	☐ Uncertain of name of condition
☐ Bell's Palsy	☐ Diabetic Retinopathy	☐ None of these apply to me

Mark any previous eye surgeries you have had:

☐ Eye Muscle Surgery	☐ Cataract Surgery	☐ Retinal Laser
☐ Metal Removed	☐ Glaucoma Laser	☐ Retinal Surgery
☐ Eyelid Surgery	☐ Glaucoma Surgery	☐ Retina injections
☐ Radial K (RK) or PRK	☐ Uncertain of surgery's name	☐ Some kind of laser
☐ LASIK	☐ Have never had any eye surgery	☐ Other:

Family History

Has any member of your family ever had the following diseases? **YES** **NO** If YES, please circle and list relation.

Blindness: _____ Glaucoma:_____ Diabetes:_____

Cataract:_____ Macular Degeneration:_____

Patient Signature: _____ Date: _____

If not completed by the patient please provide the following information:

Completed by: _____ Relationship to Patient: _____ Date: _____