Kellis Eye Center
Medical History Questionnaire

Name: ____ Date of Birth: ____________________

Do you have **allergies** to any medications? **YES** **NO**

If yes, list the medications and reactions: ____

List any **medications** you currently take: ____

____

____

Family/Social 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: ________________

Do you smoke?..................................**YES** **NO** If YES, how much? ____________ How many years? ______

Do you drink alcohol?........................**YES** **NO** If YES, how much? ____________

Do you use recreational drugs?..........**YES** **NO** If YES, what? ________________, & How? ____________

Does your work environment expose you to any hazards or chemicals? **YES** **NO**

If YES, please list____

Eye History

Has an Eye Doctor ever diagnosed or treated you for: (check all that apply)

☐ Lazy Eye (Amblyopia)	☐ Cataracts	☐ Diabetic Eye
☐ Turned Eye	☐ Glaucoma	☐ Macular Degeneration
☐ Serious Eye Injury	☐ Glaucoma	☐ Retinal Detachment
☐ Keratoconus	☐ Uveitis (Iritis)	☐ Retinal Pigmentosa
☐ Bell's Palsy	☐ None of these apply to me	☐ Other:________________

Mark any previous eye surgeries you have had:

☐ Eye Muscle Surgery	☐ Cataract Surgery	☐ Retinal Laser
☐ Metal Removed	☐ Glaucoma Laser	☐ Retinal Surgery
☐ Lid Surgery	☐ Glaucoma Surgery	☐ Some kind of laser
☐ Radial K (RK)	☐ Uncertain of surgery's name	☐ Have never had any eye surgery
☐ Other:________________		

Medical History

Have you ever been diagnosed or treated for any of the following: (check all that apply)

Circulation:	**Thyroid:**	**Heart:**	**Neuro-Muscular:**	**Urinary:**
☐ Diabetes	☐ High	☐ Congestive Heart	☐ Paralysis	☐ Pain/Discomfort
☐ High Blood Pressure	☐ Low	☐ Irregular Heartbeat	☐ Multiple Sclerosis	☐ Blood in Urine
☐ Low Blood Pressure	**Lung:**	☐ Enlarged Heart	☐ Myasthenia Gravis	**Cancer:**__________
☐ Stroke	☐ Asthma	☐ Coronary Artery	☐ Numbness	______________
☐ Blood Clots	☐ Emphysema	☐ Heart Attack	**Collagen-Vasc:**	☐ Fatigue
☐ Sickle-cell Anemia	☐ Tuberculosis	☐ Bypass Surgery	☐ Arthritis	☐ Unexpected Weight Loss or Gain
GI:	☐ Sarcoidosis	☐ Pacemaker	☐ Rheumatoid Arthritis	
☐ Crohn's Disease	☐ Shortness of Breath	☐ Chest Pain	☐ Muscle Pain	☐ Fever
☐ Ulcerative Colitis	**Psychiatric:**	**Viral:**	☐ Joint Pain	☐ Hearing Loss
Skin:	☐ Depression	☐ Herpes Simplex	☐ Swollen Joints	☐ Sinus Problems
☐ Rashes	☐ Anxiety	☐ HIV positive	**Female's Only:**	**Other:**__________
☐ Dryness	☐ Panic Attacks	☐ AIDS	☐ Currently Pregnant	______________

Patient Signature: ____ **Date:** ______________