

HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

REFERRED BY: _____

All Present Medications including Pills, Injections and Drops _____

Allergies to Medications and Drops: _____

High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Skin Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Ear/Nose/Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Stroke/Cardiovascular	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
High Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Lung problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Liver Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Blood Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Thyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Gastrointestinal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Neurological	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Multiple Sclerosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Tumors	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Pacemaker	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:
Other Illnesses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Explain:

Previous Eye Disease/Injury: _____

Previous Eye Surgery/Laser Surgery and Date: _____

Previous Operations: _____

Family History:

Cataracts: _____

Glaucoma: _____

Macular Degeneration: _____

Blindness: _____

Other: _____

Alcohol: No

Yes

Tobacco: No

Yes