Medical History Questionnaire

Print name _____ **Today's Date _____**

Primary Care Physician:_____ **Referring/ Specialty DR.**:_____

Height:_____ **Weight**:_____

Preferred Language: English O Spanish O French O Italian O Japanese O Russian O

Race: American Indian or Alaska Native O Asian O African American O Caucasian O

Ethnicity: Hispanic O Non-Hispanic O

Ocular Surgeries: (Please mark all that apply)

O No prior ocular surgery	O Retinal laser surgery	O Vitrectomy
O Foreign body removal	O PRK	O Punctal plugs
O Trabeculectomy	O Lasik	O Cataract surgery
O Blepharoplasty	O Strabismus surgery	O Corneal transplant

Others: _____

Significant Ocular Illnesses: (Please mark all that apply)

O Overall healthy	O AIDS	O Diabetes	O Rheumatoid Arthritis
O Herpes	O HIV Positive	O Hypertension	O Sjogrens
O Hypothyroidism	O Lupus	O Multiple Sclerosis	O Graves' disease

Others: _____

Medical History Questionnaire (part 2)

General Surgeries/ Operations: (Please list)

_____
_____
_____

Social History: (Please mark all that apply)

Smoking: O current every day smoker O Current some day smoker O Former smoker

O Never smoked

Alcohol Use: O Yes O No If yes how much and how often _____

Drug Use: O Yes O No If yes how much and how often _____

_____ _____

Signature **Print Name**

_____

Today's Date