Kellis Eye& Laser 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_____
Are you on a blood thinner?.....**YES NO**
Are you on oxygen?.....**YES NO**
Do you have sleep apnea?.....**YES NO**
Do you wear a CPAP or BiPAP machine?.....**YES NO**
Have you had any eye trauma in the past?.....**YES NO**

Height:_____

Weight:_____

Eye History

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

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

Mark any previous eye surgeries you have had:

- ☐Eye Muscle Surgery
- ☐Metal Removed
- ☐Lid Surgery
- ☐Radial K (RK)
- ☐Cataract Surgery
- ☐Glaucoma Laser
- ☐Glaucoma Surgery
- ☐Uncertain of surgery's name
- ☐Retinal Laser
- ☐Retinal Surgery
- ☐Some kind of laser
- ☐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:
- ☐Diabetes
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Stroke
- ☐Blood Clots
- ☐Sickle-cell Anemia

GI:
- ☐Crohn's Disease
- ☐Ulcerative Colitis

Skin:
- ☐Rashes
- ☐Dryness

Thyroid:
- ☐High
- ☐Low

Lung:
- ☐Asthma
- ☐Emphysema
- ☐Tuberculosis
- ☐Sarcoidosis
- ☐Shortness of Breath

Psychiatric:
- ☐Depression
- ☐Anxiety
- ☐Panic Attacks

Heart:
- ☐Congestive Heart
- ☐Irregular Heartbeat
- ☐Enlarged Heart
- ☐Coronary Artery
- ☐Heart Attack
- ☐Bypass Surgery
- ☐Pacemaker
- ☐Chest Pain

Viral:
- ☐Herpes Simplex
- ☐HIV positive
- ☐AIDS

Neuro-Muscular:
- ☐Paralysis
- ☐Multiple Sclerosis
- ☐Myasthenia Gravis
- ☐Numbness

Collagen-Vasc:
- ☐Arthritis
- ☐Rheumatoid Arthritis
- ☐Muscle Pain
- ☐Joint Pain
- ☐Swollen Joints

Female's Only:
Currently Pregnant

Urinary:
- ☐Pain/Discomfort
- ☐Blood in Urine

Cancer:_____
_____
- ☐Fatigue
- ☐Unexpected Weight
- ☐Loss or Gain
- ☐Fever
- ☐Hearing Loss
- ☐Sinus Problems

Other:_____
_____

Patient Signature: _____ **Date:** _____