Date: _____

Patient Name: _____ Primary Care Physician: _____

MEDICAL INFORMATION SHEET QUESTIONNAIRE

1. **Past Medical History:** Do you have?

☐ Asthma	☐ Liver Disease	☐ High Cholesterol
☐ Heart Disease	☐ Kidney Disease	☐ Gerd
☐ Lung Disease	☐ Thyroid Disease	☐ Cancer
☐ Diabetes	☐ High Blood Pressure	☐ Depression
☐ Arthritis	☐ Stroke	☐ Other _____

2. **Past Systemic Surgeries?** Please list any and the dates:

_____

_____

_____

3. **Past Eye Surgeries or Laser Surgery History:**
   - ☐ Cataract Surgery Date: _____
   - ☐ Glaucoma Surgery Date: _____
   - ☐ Retina Surgery Date: _____
   - ☐ Other _____

4. **Diagnosed Eye Disease:** *List any you have?* _____

_____

Please check yes or no if you follow a retina specialist: ☐ *Yes* ☐ *No*
If yes please write the doctor's name and date of last exam

_____

5. **Family History of Eye Diseases and relationship to the patient:**
(for example father/ mother/ sister/ brother/ etc):

☐ Glaucoma _____	☐ Blindness _____
☐ Cataracts _____	☐ Other _____
☐ Retinal _____	☐ None

6. **Medications**: *Drug Name/ Dose/ Strength*
How do you take it (for example once a day, twice a day, etc)

_____

_____

_____

_____

7. **Drug Allergies:**

_____