Medical History Questionnaire

Montgomery Eye Physicians & Surgeons
Howard Kane, O.D., M.D.
Kristen C. Zeller, M.D.
Yun Ja Park, M.D.

NAME ____ Date ______________

PAST MEDICAL HISTORY:

List all **Major Illnesses** (Diabetes, High Blood Pressure, heart disease, cancer, etc…) or **Injuries:**

_____Myocardial Infarction (Heart attack)
_____Hypertension (High blood pressure)
_____High cholesterol
_____Diabetes
_____Strole
_____Thyroid problem

_____Arthritis (Joint trouble)
_____Migraine headaches
_____Cancer (Type_______________________________)
_____Coagulation (Bleeding/Clotting) Disorder
_____Other Medical Conditions__________________
____

List all **Eye Surgeries** and **Laser** procedures you have had (include date, eye, etc …):

____

List all other **Surgeries** you have had:

____

List all **Medications** you currently take (prescription and over-the counter, vitamins, eye drops):

____

____

Do you have any **Allergies** to medications? Yes [ ] No [ ] If Yes, list the medications:

____

FAMILY HISTORY:	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Glaucoma	____	____	______________________________
Cataract	____	____	______________________________
Macular Degeneration	____	____	______________________________
Crossed or Drifting of Eyes	____	____	______________________________
Blindness	____	____	______________________________
Diabetes	____	____	______________________________
Heart Disease	____	____	______________________________
Cancer	____	____	______________________________
Other	____	____	______________________________

SOCIAL HISTORY:

Current Occupation OR Student's grade ____

Do you drink alcohol? (adults only) YES [ ] NO [ ] If yes, how much? _______________

Do you smoke? (adults only) YES [ ] NO [ ] If yes, how many packs per day? ___________