THE RETINA CENTERS OF WASHINGTON

MEDICAL QUESTIONAIRES

Name: ____ **Date:** _______________ **Age:** ______

Internal medicine Doctor name		**Telephone**	
		Fax	
Address			

Please check all that apply. Have you ever or do you presently suffer from:

	YES	NO	If YES, please provide more details
Diabetes			How long?
Heart disease			
High blood pressure			How long?
Stroke			When?
Cancer			Please specify:
			Method of treatment:
Thyroid disease			
Kidney disease			
Arthritis			
Asthma			
Bronchitis			
Do you smoke			How long?
Eye surgery			Right eye:
			Left eye:
Glaucoma			
Allergies			Food:
			Drugs:
Hepatitis			
Tuberculosis			
HIV exposure			

Family History

Eye disease			
Systemic illness			

Please list any medications that you take on a regular basis:

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