THE RETINA CENTERS OF WASHINGTON

MEDICAL QUESTIONAIRE

Name: _____ Date: _____ Age: _____

Internal medicine doctor		Telephone	
		Fax	
Endocrinologist		Telephone	
		Fax	

Allergies: Latex sensitive: ☐ Yes ☐ No Adhensive allergies: ☐ Yes ☐ No

Do you have allergy to any medication? ☐ Yes ☐ No If Yes, please list:_____

_____

Do you smoke or have you ever smoked? ☐ Yes ☐ No If Yes, how long? _____

Please check all that apply. Have you ever been diagnosed of the following conditions:

	YES	NO	DURATION/DETAILS		YES	NO	DURATION/DETAILS
Diabetes	☐	☐		Arthritis	☐	☐	
Heart disease	☐	☐		Asthma	☐	☐	
High blood pressure	☐	☐		Bronchitis	☐	☐	
Stroke	☐	☐		Hepatitis	☐	☐	
Cancer	☐	☐		Tuberculosis	☐	☐	
Thyroid disease	☐	☐	Hyperthyroidism	AIDS/HIV	☐	☐	
	☐	☐	Hypothyroidism	Kidney disease	☐	☐	
Other diagnosis not listed: List any surgeries that you had:							

Ocular history:

-Glaucoma ☐ Yes ☐ No Macular degeneration ☐ Yes ☐ No

-List any EYE SURGERIES/LASER/INJECTIONS that you have had, which eye and when:

_____

_____

Family history:

	YES	NO	
Eye disease	☐	☐	
Systemic illness	☐	☐	

Please list any medications that you are taking on a regular basis including eyedrops:

_____

_____

_____

_____

_____