LAKELAND OPHTHALMOLOGY

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Medical History Questionnaire

Today's Date ______________________ **Name** ____

Birth Date ________________________

Do you presently have any problem in these areas? If yes, please explain

Integument (skin)	Yes	No	________________
Head	Yes	No	________________
Eyes	Yes	No	________________
Ears, nose, mouth, throat	Yes	No	________________
Neck	Yes	No	________________
Bones, joints (arthritis)	Yes	No	________________
High Blood pressure	Yes	No	________________
Kidney Disease	Yes	No	________________
Thyroid Disease	Yes	No	________________
Prostate Disease	Yes	No	________________
Respiratory (lungs breathing, Asthma, Bronchitis)	Yes	No	________________
Cardiovascular (heart/blood vessels)	Yes	No	________________
Neurological system (e.g. stroke)	Yes	No	________________
Lympharies (lymph nodes, swelling)	Yes	No	________________
Hematopoietic (Blood)	Yes	No	________________
Allergic and immunologic	Yes	No	________________
Infectious (e.g. AIDS, Hepatitis)	Yes	No	________________
Psychiatric	Yes	No	________________
Diabetes	Yes	No	________________
Gastrointestinal (stomach, liver)	Yes	No	________________
High Cholesterol	Yes	No	________________

Medications you take: name, dosage, how many times a day.
(Include Vitamins, Herbal and over the counter meds)____

____

Surgeries and hospitalizations you have had in the past: ____

____

Major illnesses and/or injuries you have had in the past. ____

____

Do you have any allergies to medications **Yes** **No** ____

Are you allergic to latex? **Yes** **No** **Are you allergic to tape?** **Yes** **NO**

Are you allergic to shellfish, iodine or iodine preparations? **Yes** **No**

Any other allergies?____

Pharmacy: ____

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