Welcome to Central Montana EyeCare

Medical History Questionnaire

Name:_____ Date:_____

Updated:_____

Do you currently smoke? Yes No Have you previously smoked? Yes No If so, when did you quit?_____ How long did you smoke?_____

Health History:

Do you have history of the following:			Approximate date of diagnosis:
Diabetes:	Yes	No	
Thyroid:	Yes	No	
High Blood Pressure:	Yes	No	
Headaches:	Yes	No	
Allergies:	Yes	No	

Ocular History:

Do you have history of the following:					
Cataracts:	Yes	No	Macular Degeneration:	Yes	No
Glaucoma:	Yes	No	Diabetic Retinopathy:	Yes	No
Glaucoma Suspect:	Yes	No	Dry Eyes:	Yes	No
Retinal Detachment:	Yes	No	Flashes or Floaters:	Yes	No
Corneal Disease:	Yes	No	Glare Sensitivity/Halos:	Yes	No
Iritis/Inflammation:	Yes	No	Ocular Injuries:	Yes	No

Ocular Surgical History:

Have you had any ocular surgeries: Yes No

If yes, please explain:_____

_____

_____

Any family history of:

Diabetes:	Yes	No
Glaucoma:	Yes	No
Macular Degeneration:	Yes	No

Please list all medications that you are currently taking:

_____

_____

_____

_____

Please list any medications that you are allergic to:_____

_____