HEALTH QUESTIONNAIRE / ALLERGIES AND SENSITIVITIES

Date of last eye exam: ____________________ Physician: ____________________

Is there history of skin reaction or other unusual reaction or sickness following injection or oral administration of:

	Circle One			*What Drug or Food?*
Penicillin or other antibiotics	YES	NO	DON'T KNOW	______
Morphine, Codeine, Demerol or other narcotics	YES	NO	DON'T KNOW	______
Novocain or other anesthetics	YES	NO	DON'T KNOW	______
Aspirin, Empirin or other pain remedies	YES	NO	DON'T KNOW	______
Sulfa drugs	YES	NO	DON'T KNOW	______
Tetanus antitoxin or other serums	YES	NO	DON'T KNOW	______
Adhesive Tape	YES	NO	DON'T KNOW	______
Iodine or merthiolate	YES	NO	DON'T KNOW	______
Any other drug or medication	YES	NO	DON'T KNOW	______
Any foods, such as egg, milk or chocolate	YES	NO	DON'T KNOW	______

Drugs recently taken: *Within the past six months, have you taken:*

Cortisone	YES	NO	DON'T KNOW
Thyroid Medications	YES	NO	DON'T KNOW
Anticoagulants (blood thinners)	YES	NO	DON'T KNOW
Tranquilizers	YES	NO	DON'T KNOW
Hypotensives (high blood pressure medicines)	YES	NO	DON'T KNOW
Aspirin	YES	NO	DON'T KNOW
Other	YES	NO	DON'T KNOW

Have you ever received treatment for:

Asthma, rheumatism or rheumatic fever? (shortness of breath)	YES	NO	DON'T KNOW

What other medical conditions are you being treated for? ____________________

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What operations have you had? ____________________

Have you ever had eye surgery? YES ☐ NO ☐ *(If "yes", please list)*

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Have you ever been told you had any of the following? *(Circle where appropriate)*

Patient			**Blood Relative**		
Macular Degeneration	YES	NO	Macular Degeneration	YES	NO
Glaucoma	YES	NO	Glaucoma	YES	NO
Cataracts	YES	NO	Cataracts	YES	NO
Dry Eyes	YES	NO	Dry Eyes	YES	NO
Retinal Detachment	YES	NO	Retinal Detachment	YES	NO
Diabetes	YES	NO	Diabetes	YES	NO
Hypertension	YES	NO	Hypertension	YES	NO
Heart Problems	YES	NO	Heart Problems	YES	NO
Stroke	YES	NO	Stroke	YES	NO
Bleeding Tendency	YES	NO	Bleeding Tendency	YES	NO

Do you have any of the following? *(Check all that apply)*

- ☐ Blurred Vision at distance
- ☐ Blurred Vision at near/reading
- ☐ Floaters
- ☐ Pain in the eyes
- ☐ Redness in the eyes
- ☐ Double vision
- ☐ Can't see well with present glasses
- ☐ Eyes are sore or dry
- ☐ Eyes water excessively
- ☐ Halo effect
- ☐ Other (describe) ____________________

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