Raananah S. Katz, M.D., F.A.C.S.

Patient History Questionnaire

Name: ____________________________________

Primary Medical doctor: ______________________________ Doctor's Tel. # ________________

Please list any **MEDICATIONS** you are taking: ______________________________________

____

Please list any **EYE DROPS** you use: ____

Are you **ALLERGIC** to any medications? YES ___ NO ___ (if yes, please list below)

____

Have you ever had **EYE SURGERY** (including laser)? YES ___ NO ___
Please List:

Year	Type of surgery	Which eye	Surgeon

Do you have any of the following?

Diabetes YES ___ NO ___
High blood pressure YES ___ NO ___
Heart disease YES ___ NO ___
Lung problem
(asthma, emphysema, bronchitis) YES ___ NO ___
Thyroid disease YES ___ NO ___
Arthritis YES ___ NO ___
Neurologic problems (stroke, epilepsy) YES ___ NO ___
Blood disease
(anemia, leukemia, lymphoma, etc.) YES ___ NO ___
Cancer YES ___ NO ___
Gastrointestinal YES ___ NO ___
Muscle & Bone Problems YES ___ NO ___

Has anyone in your family had any eye diseases? (list which family members)

Glaucoma YES ___ NO ___ ______________________________
Cataract YES ___ NO ___ ______________________________
Retinal detachment YES ___ NO ___ ______________________________
Macular degeneration YES ___ NO ___ ______________________________
Strabismus (eye muscle problem) YES ___ NO ___ ______________________________

______________________________________ ______________________

Patient Signature **Date**

FORM 100D