MEDICAL HISTORY QUESTIONNAIRE

NAME____DOB___/___/______ VISIT DATE___/_____/_____

List all major illnesses (glaucoma, high blood pressure, heart attack, etc.) or injuries (concussion, etc.) you have had:

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List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) please include the date(s):

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List all medications you are using at present, please include over the counter medications and vitamins:

Eye Medications **All other medications**

NAME	DOSE	FREQ.	EYE	NAME	DOSE	FREQ.

Are you allergic to any food or medication? Yes No Are you allergic to Latex? Yes No

If yes, please list the substance(s) with type of reaction:

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To assist you in receiving your medications in a timely manner, our practice sends prescriptions electronically. Please list the name and location of your pharmacy.

Pharmacy Name:________________________________Phone Number:____________________________

Address:_____________________________________City/State:________________________________

Do you use Ft. Bragg to obtain your medication? Yes No

If you use a mail order pharmacy, please list that information here:___________________________

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