BARIBEAU
CATARACT AND LASER
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MEDICAL HISTORY QUESTIONAIRE

Name: _____ DOB: ____/____/____ Today's Date: _____
Name of Primary Doctor: _____ City/State_____ Phone: _____

Please identify which eye surgery you have had, if any: (Please circle YES or NO)
Cataract Surgery YES / NO :
Right eye: Date/Doctor_____ Left eye: Date/Doctor_____
Glaucoma Surgery YES / NO :
Right eye: Date/Doctor_____ Left eye: Date/Doctor_____
Retinal Surgery YES / NO :
Right eye: Date/Doctor_____ Left eye: Date/Doctor_____
Cataract Surgery YES / NO :
Right eye: Date/Doctor_____ Left eye: Date/Doctor_____
Other prior eye conditions or concerns: □ NONE
_____
List Eye Drops or Ointments that you use now (name of product, which eye, and how often) : □NONE
_____
_____
Current Medication List (including dosage): □ NONE □ SEE ATTACHED LIST
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
Have you been diagnosed with any of the following:
□High Blood Pressure □Heart Disease □Arthritis □Asthma/COPD □Cancer/Type? _____
□High Cholesterol □Stroke □Thyroid – High or Low (please circle one) □Diabetes/Type?_____
Other medical history NOT listed above: □ NONE
_____
_____
Please list prior surgeries (other than eye surgeries): □ NONE □ SEE ATTACHED LIST
_____
_____
Allergies: (Please list any drugs/substance allergy): □ NONE □ SEE ATTACHED LIST

	Drug/Substance Name:	*Type of Reaction:*	*Severity: (Circle one)*
Allergy to:	_____	_____	mild/ moderate/ severe
Allergy to:	_____	_____	mild/ moderate/ severe
Allergy to:	_____	_____	mild/ moderate/ severe
Allergy to:	_____	_____	mild/ moderate/ severe

Smoking: □ every day smoker □ social smoker □ former smoker □ never smoked
Alcohol Use: □ YES □ NO If yes, how much and how often? _____
Drug Use: □ YES □ NO If yes, what and how often? _____