

Manzo Eye Care
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HISTORY QUESTIONNAIRE

NAME: _____

DATE: _____

GENDER: MALE FEMALE

Do you presently wear: Glasses _____ Contacts _____ Type: HARD SOFT

ALLERGIES: _____

MEDICAL DOCTOR _____

ADDRESS _____

PHONE _____

Please list all MEDICATIONS you are currently taking:

(including eye drops, or aspirin-like medications or steroids taken in the past two months)

Are you on Flomax, Cardura (Doxazosin) or any other medications for Prostate problems? NO YES (Please list)

Please list all SURGICAL OPERATIONS you have had: _____

Are there any other MEDICAL CONDITIONS OR PROBLEMS we should know about? _____

Yes	No	Do You Have a History Of:	Yes	No	Do You Have A Family History Of:
		Cataracts			Diabetes
		Eye Infections			Heart Disease
		Eye Injuries Type:			Hypertension
		Eye Surgeries Type:			Arthritis
		Glaucoma			Cancer
		Lazy Eye			Migraine Headaches
		Retinal Problems			Cataracts
		Bleeding Tendencies			Glaucoma
		Breathing/Lung Problems			Macular Degeneration
		Smoking			
		Diabetes			
		Drinking More Than Two Alcoholic Beverages a Day			
		Ears, Nose or Throat Problems			
		Gastrointestinal Problems			
		Heart Attack, (MI), or Cardiac Arrest			
		Stroke			
		Heart Trouble, Palpitations, Racing, Irregular Heart Beat			
		Hypertension (High Blood Pressure)			
		Kidney Failure			
		Liver Disease, Hepatitis, or Yellow Jaundice			
		Muscle or Bone Disease			
		Skin Disease			
		Neurologic Disease			
		Persistent Headache Frequency:			
		Psychiatric Disease			
		Urinary Problems			