RAGHUNAND SASTRY M.D. PC.

Medical History Questionnaire

Name:_____ Age:_____

Birthdate:_____

Reason for visit:_____

Medical Problems

Diabetes	Yes____	No____	How Long?_____
High blood pressure	Yes____	No____	How Long?_____
High cholesterol	Yes____	No____	How Long?_____
Heart disease	Yes____	No____	How Long?_____
Irregular heart beat	Yes____	No____	How Long?_____
Stroke	Yes____	No____	How Long?_____
Headaches/Migraine	Yes____	No____	How Long?_____
Asthma/Bronchitis	Yes____	No____	How Long?_____
Arthritis	Yes____	No____	How Long?_____
Allergies/Sinus problems	Yes____	No____	How Long?_____
Kidney disease	Yes____	No____	How Long?_____
HIV/AIDS	Yes____	No____	How Long?_____
Liver problems	Yes____	No____	How Long?_____
Sexually transmitted disease (STD)	Yes____	No____	How Long?_____
Anemia/problem with blood	Yes____	No____	How Long?_____
(For women) Are you currently pregnant?	Yes____	No____	How Long?_____

Have you ever been hospitalized?_____

Other Health problems:_____

Does anyone in your family have eye problems such as: (circle all that apply)

Cataracts Diabetes Macular Degeneration Glaucoma Retinal Detachment

Is anyone in your family blind for any reason? Yes_____ No_____

(If yes, please state reason)_____

Do you drink? Yes_____ No_____

Do you smoke? Yes_____ No_____

Surgical History

Cataract surgery	Yes____	No____	When?_____
Other surgery	Yes____	No____	When?_____
Laser surgery	Yes____	No____	When?_____

Medications (Please list all medications your are currently using)

_____

_____

Allergies to medications:_____

_____

_____ _____

Raghunand Sastry, M.D. Date