**JOSEPH D. WALRATH, MD – OCULOPLASTIC SURGERY**
800 MT. VERNON HWY NE
SUITE 135
ATLANTA, GA 30328

COORDINATOR: 770-804-1684 EXT.119
CALL CENTER: 866-527-3722

**Medical History Questionnaire**

**Name**: ___________________________________________ **D.O.B**. _______________ **Date**____________________

Date of **Last Eye Exam**____________________________ Referred by _____________________________________________

List any medications you **currently** take (prescription and over-the-counter)_______________________________________

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Do you have **allergies**? Yes No

If YES, list the medications/allergies ____________________________________________________________________

__________________________________________________________________________________________________________

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussions, etc.) ______

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

List any **surgeries** you have had (cataract, tonsillectomy, etc.)__________________________________________________

__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

**<u>Family History</u>**: M=Mother F=Father S=Sibling GP=Grandparent

| Disease | Yes | No | Disease | Yes | No |
|---|---|---|---|---|---|
| Blindness | | | Cataracts | | |
| Glaucoma | | | Arthritis | | |
| Cancer | | | Diabetes | | |
| Heart Disease or Hypertension | | | Kidney Disease | | |
| Lupus | | | Stroke | | |
| Thyroid Disease | | | Other | | |

**<u>Social History</u>**

Do you drink alcohol? Yes No If Yes, frequency: _____#glasses per __ Day __ Week __Month

Do you smoke? Yes No If Yes, Frequency: _____#packs per ___ Day __ Week __Month

Patient Signature: ______________________________________________ Date: _____________________________

Physician's Signature: ___________________________________________ Date: _____________________________
Updated: _________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________