Medical Questionnaire

Please complete the following questions: Write answer or *circle / delete as appropriate

1. Title
2. Your name
3. Your date of birth

4. Do you drive a car? Yes / No*

5. Are you Allergic to any medications? Yes / No*
- if yes please list

Please list all prescribed medications that you are (supposed to be) taking: (dosages are not required)

6. Do you smoke? Yes / No*
7. Do you drink alcohol? Yes (little, light (social), moderate, too much) / No*

8. Do you have any of the following eye conditions?

Diabetic retinopathy	Yes / No*
Age related macular degeneration	Yes / No*
Glaucoma	Yes / No*
A "Lazy eye"	Yes / No*
Retinal detachment surgery	Yes / No*
Squint surgery	Yes / No*

9. Do you have, or had any of the following medical conditions?

Heart disease – heart failure / heart attack / angina	Yes / No*
Irregular pulse (e.g. AF)	Yes / No*
Emphysema / Asthma / COPD	Yes / No*
High blood pressure	Yes / No*
Diabetes	Yes / No*
High cholesterol	Yes / No*
CVA (a stroke)	Yes / No*
TIA (transient ischaemic attack – "mini' stroke)	Yes / No*
Thyroid disease	Yes / No*
Fits, seizures, epilepsy	Yes / No*
Memory disturbance	Yes / No*
Cancer	Yes / No*

10. Do you have any family history of?
Glaucoma / ocular hypertension Yes / No*
Retinal disease Yes / No*

Signed

Dated …… / …… / 20……