

MEDICAL HISTORY

Name _____ Date _____

Unable to obtain due to _____

Name of Primary Care or Medical Doctor _____

Phone number _____

Personal Medical History: (Circle yes or no for each category)

yes no High Blood Pressure ___# of years yes no Psychiatric Disorder _____
yes no Diabetes IDDM/Type 11 ___# of years yes no Blood Disease _____
yes no Cancer _____ yes no Auto-Immune _____
yes no Heart Disease _____ yes no Thyroid _____
yes no Breathing Problems _____ yes no Migraines _____
yes no Kidney Disease _____ yes no Muscle/Skeletal _____
yes no Circulation Problems _____ yes no Other _____
yes no Ear/Nose/Throat _____ yes no Do you Smoke? ___#packs/day
yes no Stomach Problems _____ yes no Do you Drink Alcohol? ___#drinks/wk
yes no Skin Disorders _____ yes no Do you live alone? _____
yes or no Do you use illicit drugs _____.

Surgical/Hospitalization History (Include year, and reason for hospitalization or surgery)

List all Medications (prescription or over the counter), Vitamins, Eye Drops
you are currently using, Include Dosage: _____

List all Medication Allergies _____

Your ocular history (Have you been diagnosed with any of the following in the past?)

yes no Cataracts _____ yes no Corneal Disease _____
yes no Retinal Disorder _____ yes no Glaucoma _____
yes no Crossed Eyes _____ yes no Injury to Eye _____
yes no Other Eye Disorders _____
yes no Eye Surgery(Including LASIK) _____

Family History (Has anyone in your family had any of the following?) Note relation to patient: F- Father
M-Mother P-Paternal M-Maternal GF-Grandfather GM- Grandmother S-Sister B-Brother U-Uncle
A-Aunt

yes no Glaucoma _____ yes no Cataract _____ yes no Retinal Disorder _____
yes no Heart Disease _____ yes no Diabetes _____ yes no Hypertension _____
yes no Other General Health Problems _____
Other Eye Problems _____