



**Patient Medical History**

(Please print the following information)

PATIENT MEDICAL HISTORY

LIST ALL ALLERGIES: \_\_\_\_\_ NO KNOWN ALLERGIES \_\_\_\_\_

Y N Lung Disease: Asthma\_\_TB\_\_Other\_\_\_\_\_ Y N Blood Disorder: Anemia\_\_Bruising/Bleeding\_\_\_\_\_

Y N Kidney Disease-Type: \_\_\_\_\_ Other \_\_\_\_\_

Y N Arthritis-Type: Osteo\_\_Rheumatoid\_\_ Y N G.I. Disorder: Ulcer\_\_\_\_\_ Gallbladder\_\_\_\_\_

Y N Diabetes: Diet\_\_Insulin\_\_No. of Yrs\_\_\_\_\_ Hepatitis\_\_\_\_\_ Other\_\_\_\_\_

Y N Thyroid Disease-Type: Hyper\_\_Hypo\_\_ Y N Seasonal Allergies\_\_ Sinus Problems\_\_\_\_\_

Y N Neurological Disease \_\_\_\_\_ Y N High Blood Pressure \_\_\_\_\_ # of Yrs \_\_\_\_\_

Y N Headaches or Migraines \_\_\_\_\_ Y N Stroke \_\_\_\_\_

Y N Cancer-Type: \_\_\_\_\_ Y N Seizures, Convulsions, Tremors or Fainting \_\_\_\_\_

Y N Central Nervous System Disorders \_\_\_\_\_ Y N Temporal Arteritis \_\_\_\_\_

Y N Heart Disease \_\_\_\_\_ Y N Recent Fever? \_\_\_\_\_

Cardiovascular: Heart Attack \_\_\_\_\_ Y N (Women) Are You Pregnant or Nursing? \_\_\_\_\_

Angina \_\_\_\_\_ Other \_\_\_\_\_ Y N Recent Change in Weight \_\_\_\_\_ Appetite \_\_\_\_\_

Y N Carotid Artery Disease \_\_\_\_\_ Y N Do You Use Recreational Drugs? \_\_\_\_\_

Y N Immune System Disorders: Leukemia \_\_\_\_\_ Y N Do You Smoke? Packs Per Day \_\_\_\_\_ Week \_\_\_\_\_

Lupus\_\_ HIV\_\_ AIDS\_\_ MRSA \_\_\_\_\_ Y N Do You Drink ? #Per Day \_\_\_\_\_ Week \_\_\_\_\_ Month \_\_\_\_\_

Y N Any Other Disease/Disorder/Injury Not \_\_\_\_\_ Y N Do You Live Alone? \_\_\_\_\_

Listed \_\_\_\_\_

LIST ALL MEDICATIONS & VITAMINS YOU ARE CURRENTLY TAKING

\_\_\_\_\_  
\_\_\_\_\_

LIST ANY EYEDROPS YOU ARE CURRENTLY USING

Name: \_\_\_\_\_ How Often? \_\_\_\_\_

Name: \_\_\_\_\_ How Often? \_\_\_\_\_

PATIENT PRINTED NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

(Be sure to complete the second page - Your Eye History)



YOUR EYE HISTORY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS IN THE PAST?

Y N Cataracts? Y N Corneal Disease? Y N Retinal Disease? Y N Glaucoma? Y N Iritis?

Y N Crossed Eyes? Eye Injury, Which Eye and Injury Date? \_\_\_\_\_

Y N Any Other Eye Disorders? \_\_\_\_\_

Cataract Surgery? Y N Date of Surgery: Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Other Surgery & Date of Surgery: Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

ANY CHANGES IN YOUR DAILY LIVING ACTIVITIES DUE TO VISUAL CHANGES?

Watching TV \_\_\_\_\_ Seeing Street Signs \_\_\_\_\_ Night Driving \_\_\_\_\_ Reading \_\_\_\_\_ Computer \_\_\_\_\_

Sewing \_\_\_\_\_ Tennis \_\_\_\_\_ Golf \_\_\_\_\_ Other \_\_\_\_\_

When Was Your Last Eye Exam? \_\_\_\_\_ Do You Wear glasses? Y N Contact Lenses? Y N

Who was your Previous Eye Doctor? \_\_\_\_\_

SURGICAL HISTORY

Date: \_\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_\_ Type: \_\_\_\_\_

FAMILY HISTORY: (Note Relation to Patient Using Abbreviations: F=Father M=Mother P=Paternal

S=Sister B=Brother GF=Grandfather GM=Grandmother U=Uncle A=Aunt)

Y N Glaucoma \_\_\_\_\_ Y N Retinal Detachment \_\_\_\_\_

Y N Cataracts \_\_\_\_\_ Y N Other Eye Problems \_\_\_\_\_

Y N Corneal Disease \_\_\_\_\_ Y N Diabetes \_\_\_\_\_

Y N Macular Degeneration \_\_\_\_\_ Y N Heart Conditions \_\_\_\_\_

Y N Retinitis Pigmentosa \_\_\_\_\_ Y N Stroke \_\_\_\_\_

Y N Diabetic Retinopathy \_\_\_\_\_ Y N Other General Health Problems \_\_\_\_\_

PATIENT PRINTED NAME \_\_\_\_\_ DOB \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_