MEDICAL HISTORY

TODAY'S DATE

NAME _____ _____
LAST FIRST MIDDLE INITIAL DATE OF BIRTH

YES	NO		YES	NO	
○	○	High Blood Pressure # of yrs_____	○	○	Psychiatric Disorder
○	○	Diabetes # of yrs_____	○	○	Skin Disorders
○	○	Cancer	○	○	Allergic / Immune
○	○	Heart Disease	○	○	Thyroid
○	○	Breathing Problems	○	○	Migraines/Headaches
○	○	Kidney Disease	○	○	Muscle/Skeletal
○	○	Circulation Problems	○	○	Other _____
○	○	Ear/Nose/Throat	○	○	Do you smoke? _____ # packs/day
○	○	Stomach Problems	○	○	Do you drink alcohol? _____ # drinks/day
○	○	Neurological Disorders	○	○	Do you live alone?

FAMILY / MEDICAL DOCTOR(S) _____ **PHONE** _____

_____ **PHONE** _____

SURGICAL / HOSPITALIZATION HISTORY (within the last 10 years) -- Please include dates:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION HISTORY -- Please list all medications you are currently taking (include dosage):

Medication	Dosage	Medication	Dosage

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

_____ _____
_____ _____

ARE YOU ALLERGIC TO THE FOLLOWING ITEMS: ☐ NO ☐ **YES --- If YES, please circle or list all that apply.**

• **LATEX** • **RUBBER** • **EGGS** • **SOYBEANS** • **PEANUTS** • **OTHER** _____

OCULAR HISTORY -- Have you been diagnosed with any of the following in the past?

YES	NO		YES	NO	
☐	☐	Cataracts _____	☐	☐	Corneal Disease _____
☐	☐	Retinal Disorder _____	☐	☐	Glaucoma _____
☐	☐	Crossed Eyes _____	☐	☐	Injury _____
☐	☐	Other Eye Disorders _____			
☐	☐	Eye Surgery _____			

FAMILY HISTORY -- Has anyone in your family had any of the following? Please note relation to patient:
F - Father, **M** - Mother, **P** - Paternal, **M** - Maternal, **S** - Sister, **B** - Brother, **GF** - Grandfather, **GM** - Grandmother

YES	NO		YES	NO	
☐	☐	Cataract _____	☐	☐	Heart Disease _____
☐	☐	Retinal Disorder_____	☐	☐	Diabetes _____
☐	☐	Glaucoma _____	☐	☐	Hypertension _____
☐	☐	Other Eye Problems _____			
☐	☐	Other General Health Problems _____			

OFFICE: History Updated (Date & Initials)

R 10/09