MEDICAL HISTORY
(MUST BE FILLED OUT IN BLACK INK)

Name_____

Date of Birth:_____ Date of last eye exam:_____

List any medication you currently take (RX and over-the-counter)

_____

_____

_____

Do you have allergies to any medications? YES _____ NO _____ If YES, please list medications_____

_____

List all MAJOR ILLNESSES (Glaucoma, Diabetes, High Blood Pressure, Heart Attack)

_____

List all MAJOR INJURIES (Concussion, Fractures, Etc.)

_____

List any SURGERIES you have had (Cataract, Appendectomy, Etc.)

_____

_____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (Poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (Fever, heat stroke, weight loss, weight gain, unusually tired, etc.)			
EARS, NOSE, THROAT (Hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (High BP, racing pulse, etc.)			
RESPIRATORY (Congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (Stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (Painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Are you nursing?			

MUSCLES, BONES, JOINTS (Joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (Pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (Numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (Bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (Sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

Has any member of your family had these diseases? (Circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Which family member was diagnosed with these diseases? MOTHER, FATHER, GRANDPARENT, SIBLING

SOCIAL HISTORY	**YES**	**NO**	
Does your vision limit activities of daily living?			Circle all that apply - Driving, reading, sports, work, other
Have you ever had a blood transfusion?			
Do you drink?			If YES, how much?_____
Do you smoke?			If YES, how much?_____ How many years? _____

Patient's Signature _____**Date** _____

Physician's Signature _____
Date_____

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