PATIENT MEDICAL HISTORY FORM

Name of Family Physician:_____Date of Last Physical:_____

CURRENT MEDICATIONS (Rx or over the counter, list name of medications including eye drops, vitamins & birth control pills)

_____

ALLERGIES TO MEDICATIONS? ☐ Yes ☐ No If yes, which: _____

List all major illnesses (glaucoma, diabetes, high cholesterol, high blood pressure, etc) or injuries (concussion, etc):

_____

List any surgeries you have had (cataract, appendectomy, etc.)_____ _____

Do you smoke? ___yes _____no if Yes, how much?_____ How many years?_____

Do you drink alcohol? ____yes ____no if Yes, how much?_____

REVIEW OF SYSTEMS

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

	YES	NO	Details (condition, date of diagnosis, and treatment)
EYES(distance blur, near blur, eye pain, tearing, redness, dry eyes, etc)	☐	☐	
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)	☐	☐	
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (high blood pressure, racing pulse, etc)	☐	☐	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	☐	☐	
FEMALES Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, seizures, etc.)	☐	☐	
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☐	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☐	
BLOOD / LYMPH (bleeding, high cholesterol, anemia, sicle cell, blood transfusions, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)	☐	☐	
CANCER (please list type)	☐	☐	
OTHER	☐	☐	

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings: living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Cataract	☐	☐	
Retinal Detachment/Disease	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Crossed Eyes/ Lazy Eyes	☐	☐	
Blindness	☐	☐	
Cancer	☐	☐	
Heart Disease	☐	☐	
Lupus	☐	☐	
Thyroid Disease	☐	☐	