MEDICAL HISTORY

Name: _____DOB: _____ Date: _____

Please fill out all sections. If not applicable, write "none".

HEALTH HISTORY QUESTIONS

Arthritis/Rheumatoid	No	Yes
Asthma	No	Yes
Cancer (What type?_____)	No	Yes
Carotid Artery Disease	No	Yes
Chemical Dependency	No	Yes
Diabetes: Insulin or Non-Insulin Dependent?	No	Yes
Drug Sensitivities	No	Yes
Emphysema / COPD	No	Yes
Epilepsy	No	Yes
Fibromyalgia	No	Yes
Gastrointestinal Disease	No	Yes
Hayfever	No	Yes
Head or Spinal Injuries	No	Yes
Heart Disease	No	Yes
Hepatitis – history of	No	Yes
High Blood Pressure	No	Yes
High Cholesterol	No	Yes
Infectious/Communicable Disease	No	Yes
Kidney Disease	No	Yes
Lung	No	Yes
Migraines	No	Yes
Nervous Disorder	No	Yes
Neurological Disease	No	Yes
Pacemaker	No	Yes
Permanent Defect (from Illness, Disease or Injury)	No	Yes
Pregnancy	No	Yes
Psychiatric Disorder or Depression	No	Yes
Seizures, Convulsions, Fainting	No	Yes
Seasonal allergies	No	Yes
Shingles – history of	No	Yes
Skin Conditions	No	Yes
Stomach	No	Yes
Stroke	No	Yes
Staph or MRSA – history of	No	Yes
Thyroid Conditions	No	Yes
Tuberculosis	No	Yes

Other: _____

ALLERGIES/SENSITIVITIES TO MEDICATIONS

_____

_____

_____

_____

CURRENT MEDICATIONS/DOSAGE*

PLEASE FILL OUT ENCLOSED PATIENT MEDICATION LIST

OCULAR HISTORY

Cataract	No	Yes
Macular Degeneration	No	Yes
Glaucoma	No	Yes
Lazy Eye	No	Yes

Other: _____

PREVIOUS EYE SURGERIES

_____

_____

_____

OTHER SURGERIES

_____

_____

_____

_____

SOCIAL HISTORY

Smoking? No Yes Amount _____ Years _____

Drinking? No Yes Amount _____ Years _____

Caffeine? No Yes Amount per day _____

Recreational Drugs? No Yes Formerly _____

Live Alone? No Yes

Do you drive? No Yes

Occupation: _____

FAMILY HISTORY Who?

Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Cancer	No	Yes	_____
Stroke	No	Yes	_____
Macular Degeneration	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Lazy Eye	No	Yes	_____
Retinal Detachment	No	Yes	_____
Blindness	No	Yes	_____

Other: _____