

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Please List All Medications You Are Allergic To:

• REVIEW OF SYSTEMS

Yes No Yes No
Diabetes # of yrs. Hepatitis
High Blood Pressure # of yrs. HIV/AIDS
Heart Disease Arthritis (osteo/rheumatoid)
Kidney Disease Autoimmune Disease Lupus Crohn's MS
Neurological Disease Fibromyalgia Chronic Fatigue Syn. Other
Carotid Artery Disease Migraines
Stroke Head or Spinal Injuries
Cancer Seizure, Convulsions or Fainting
Thyroid Disease? (Women) Are you Pregnant or Nursing?
Gastrointestinal Disease - Type Permanent defect from Illness, Disease or Injury?
Respiratory Disease - Type Other:

• SOCIAL HISTORY

Do you live alone? Alcohol Use? # Drinks per Day/Week/Month
Are you currently staying in a nursing home or rehab center?
Tobacco Use-Cig./Pks. per Day? Week? Psychiatric disorders?
Quit? Year? Other:

• Please List All Medications You Are Currently Taking: (Continue on extra sheet if needed.)

(Eye Medications)

_____ ()
_____ ()
_____ ()

• YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

Yes No Yes No
Cataracts Crossed Eyes/Lazy Eye
Glaucoma Iritis/Inflammation in eye
Retinal Disease Corneal Disease
Injury Other Eye Disorders

- **FAMILY HISTORY** (Has anyone in your family – **blood relative** – had any of the following?)

Note relation to Patient: F-Father M-Mother B-Brother S-Sister GF-Grandfather GM-Grandmother U-Uncle A-Aunt

Yes No		Yes No		Yes No		Yes No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____		Macular Degen. _____		Retinal Detachment _____		Diabetes _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cataracts _____		Corneal Disease _____		Diabetic Retinopathy _____			
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems _____					

- **YOUR SURGICAL HISTORY** (Please include date and type: Continue on extra sheet if needed.)

Patient

Signature: _____ Date: _____ Reviewed by: _____