Guardian Eye Associates, PLC
New Patient Medical History

Name: ____ Date: ____________________

Address: ______________________________________

______________________________________ Date of Birth: ______________

Have you had any of the following? (if YES, please explain below)

Glasses or Contacts	YES	NO	
Laser eye surgery	YES	NO	
Other eye surgery	YES	NO	
Other eye problems	YES	NO	

Do you have any of the following conditions? If YES, please explain.

Fever or chills	YES	NO	
Recent weight change	YES	NO	
Fatigue or overall weakness	YES	NO	
Rash or skin problems	YES	NO	
Hearing loss	YES	NO	
Sinus trouble	YES	NO	
Mouth sores or disease	YES	NO	
Lung disease	YES	NO	
Heart disease	YES	NO	
High blood pressure	YES	NO	
Stomach or intestinal problem	YES	NO	
Liver disease	YES	NO	
Diabetes	YES	NO	
Thyroid disease	YES	NO	
Kidney problem	YES	NO	
Arthritis	YES	NO	
Back or neck pain	YES	NO	
Cancer	YES	NO	
Anemia	YES	NO	
Bleeding disorder	YES	NO	
Infectious disease	YES	NO	
Stroke/Neurologic disorder	YES	NO	
Depression/Psychiatric problem	YES	NO	

Date of your most recent physical examination: ____

Who is your primary physician? Name/City/State:____

(OVER)

List any other major illness, hospitalizations and surgeries (with date if possible).

____
____
____

List all medications you currently take (name, dosage, frequency).

Eye Medications:____

____

Other Medications: ____

____

Are you allergic to any medications?	YES	NO
If yes, Please List:		

Have any family members or relatives had any of the following conditions? List relationship to you.

Cataract	YES	NO
Glaucoma	YES	NO
Macular Degeneration	YES	NO
Retinal Detachment	YES	NO
Diabetic Retinopathy	YES	NO
Blindness	YES	NO
Diabetes	YES	NO
Heart Disease	YES	NO
Cancer	YES	NO

Your occupation:			
Martial Status:	Married	Single	Widow(er)
Do you drive?		YES	NO
Can you read small print (news print)?		YES	NO
Do you smoke tobacco?		YES	NO
Do you drink alcohol?		YES	NO
Do you use mind-altering drugs?		YES	NO

FOR OFFICE USE ONLY

☐ I have reviewed this medical history.
☐ I have made additions to this medical history as noted above or in the exam form.

_____________________________________MD Date: ____________________ Tech: _______________