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	
☐	☐	**Glaucoma _____**	☐	☐	**Macular Degen. _____**	☐	☐	**Retinal Detachment _____**	☐	☐	**Diabetes _____**
☐	☐	**Cataracts _____**	☐	☐	**Corneal Disease_____**	☐	☐	**Diabetic Retinopathy_____**			
☐	☐	**Other Eye Problems_____**									

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

_____

_____

_____

Patient

Signature: _____Date: _____ Reviewed by: _____