

# MEDICAL HISTORY

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

NICK NAME: \_\_\_\_\_

PHONE # \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

NAME OF FAMILY MEMBER: \_\_\_\_\_

FAMILY DOCTOR NAME: \_\_\_\_\_

PHONE # OF FAMILY MEMBER: \_\_\_\_\_

PAST EYE SURGERIES / INJURIES: \_\_\_\_\_

OTHER SURGERIES: \_\_\_\_\_

EYE MEDS: \_\_\_\_\_

OTHER MEDS: \_\_\_\_\_

**ALLERGIES TO MEDICATIONS OR FOOD:** \_\_\_\_\_

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS (YES OR NO) IF YES PLEASE EXPLAIN:

DIABETES/THYROID \_\_\_\_\_ HIGH BLOOD PRESSURE \_\_\_\_\_ HEART DISEASE \_\_\_\_\_

STROKE \_\_\_\_\_ CANCER \_\_\_\_\_ ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

HAVE YOU EVER HAD ANY EYE DISEASE:  YES  NO IF YES, EXPLAIN: \_\_\_\_\_

DO ANY MEMBERS OF YOUR FAMILY HAVE A MEDICAL OR EYE DISEASE:  YES  NO IF YES, EXPLAIN: \_\_\_\_\_

DO YOU HAVE ANY MEDICAL PROBLEMS WE NEED TO BE AWARE OF:  YES  NO IF YES, EXPLAIN: \_\_\_\_\_

ARE YOU CURRENTLY HAVING ANY PROBLEMS WITH THE FOLLOWING: IF YES EXPLAIN:

FEVER OR WEIGHT LOSS/FATIGUE  YES  NO \_\_\_\_\_

EAR/NOSE/THROAT (HEARING LOSS/SINUS)  YES  NO \_\_\_\_\_

CARDIOVASCULAR (CHEST PAIN, IRRG. HEARTBEAT)  YES  NO \_\_\_\_\_

RESPIRATORY (SHORTNESS OF BREATH, WHEEZING)  YES  NO \_\_\_\_\_

URINARY PROBLEMS (PAIN OR DISCOMFORT, BLOOD IN URINE)  YES  NO \_\_\_\_\_

SKIN PROBLEMS (RASHES, EXCESSIVE DRYNESS)  YES  NO \_\_\_\_\_

MUSCULOSKELETAL (MUSCLE ACHES, JOINT PAIN, ARTHRITIS)  YES  NO \_\_\_\_\_

NEUROLOGICAL (NUMBNESS, WEAKNESS, HEADACHES)  YES  NO \_\_\_\_\_

HEMATOLOGIC (BLEEDING TENDENCIES, ANEMIA)  YES  NO \_\_\_\_\_

GASTROINTESTINAL PROBLEMS (HEARTBURN, ABDOMINAL PAIN, DIARRHEA)  YES  NO \_\_\_\_\_

ALLERGIC/IMMUNOLOGIC (SEASONAL ALLERGIES, HAY FEVER)  YES  NO \_\_\_\_\_

PSYCHIATRIC PROBLEMS (DEPRESSION, ANXIETY)  YES  NO \_\_\_\_\_

SOCIAL HISTORY: DO YOU SMOKE?  YES  NO \_\_\_\_\_

DO YOU CONSUME ALCOHOL?  YES  NO \_\_\_\_\_

HAVE YOU EVER HAD TB?  YES  NO \_\_\_\_\_

DO YOU WORK? (HOW MANY HOURS)  YES  NO \_\_\_\_\_

ATTENDING PHYSICIAN \_\_\_\_\_