

MEDICAL HISTORY FORM

NAME: _____ **BIRTHDATE:** ____ / ____ / ____ **DATE:** _____

REASON FOR YOUR VISIT: Please describe. _____

MEDICAL HISTORY:

Select any of the following conditions that you currently have, and when you were diagnosed:

Are you currently pregnant? YES

- | | |
|---|---|
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Headaches _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Hearing Loss _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Atrial Fibrillation _____ | <input type="checkbox"/> HIV / AIDS _____ |
| <input type="checkbox"/> Bone Marrow Transplant _____ | <input type="checkbox"/> Hypercholesterolemia _____ |
| <input type="checkbox"/> BPH _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Leukemia _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Lymphoma _____ |
| <input type="checkbox"/> Coronary Heart Disease _____ | <input type="checkbox"/> Radiation Treatment _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> End Stage Kidney Disease _____ | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> GERD _____ | <input type="checkbox"/> Other _____ |

PAST SURGERIES: Have you had any surgeries? If yes, please list what procedure and date of surgery:

OCULAR HISTORY:

Select any of the following conditions that you current have, which eye and when you were diagnosed:

- | | |
|--|--|
| <input type="checkbox"/> Allergic Conjunctivitis _____ | <input type="checkbox"/> Macular Pucker _____ |
| <input type="checkbox"/> Amblyopia / Lazy Eye _____ | <input type="checkbox"/> Narrow Angles _____ |
| <input type="checkbox"/> Blepharitis _____ | <input type="checkbox"/> Ocular Hypertension _____ |
| <input type="checkbox"/> Cataract _____ | <input type="checkbox"/> Ophthalmic Migraine _____ |
| <input type="checkbox"/> Contact Lenses _____ | <input type="checkbox"/> Pseudoexfoliation _____ |
| <input type="checkbox"/> Corneal Dystrophy _____ | <input type="checkbox"/> Retinal Detachment _____ |
| <input type="checkbox"/> Diabetic Retinopathy _____ | <input type="checkbox"/> Retinal Tear / Hole _____ |
| <input type="checkbox"/> Dry Eyes _____ | <input type="checkbox"/> Strabismus _____ |
| <input type="checkbox"/> Glasses _____ | <input type="checkbox"/> Posterior Vitreous Detachment _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Vitreous Floaters _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Other: _____ |

PAST SURGERIES: Have you had any eye surgeries? If yes, please list what procedure, which eye and date of surgery:

MEDICATIONS:

List any current medications (including oral contraceptives, aspirin, over the counter medications and home remedies):

ALLERGIES: List any **medication** or **environmental** allergies:

SOCIAL HISTORY: *This information is kept strictly confidential*

I prefer to discuss my social history information directly with my doctor. (Check box)

Smoking Status: Non-smoker Current every day Current some days
 Cigar smoker Tobacco smoker How much (pk/day) _____
 Former smoker, date quit: _____ Total years smoking _____

Do you drink alcohol? No Yes If yes, type/amount/how long _____

Do you do illegal drugs No Yes If yes, type/amount/how long _____

Do you drive? No Yes Daytime Nighttime

FAMILY HISTORY:

Please indicate any family history (parents, grandparents, siblings or children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Amblyopia / Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____