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

- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial Fibrillation _____
- ☐ Bone Marrow Transplant _____
- ☐ BPH _____
- ☐ Cancer _____
- ☐ COPD _____
- ☐ Coronary Heart Disease _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ End Stage Kidney Disease _____
- ☐ GERD _____
- ☐ Headaches _____
- ☐ Hearing Loss _____
- ☐ Hepatitis _____
- ☐ HIV / AIDS _____
- ☐ Hypercholesterolemia _____
- ☐ Hypertension _____
- ☐ Leukemia _____
- ☐ Lymphoma _____
- ☐ Radiation Treatment _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Thyroid Disorder _____
- ☐ 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:

- ☐ Allergic Conjunctivitis _____
- ☐ Amblyopia / Lazy Eye _____
- ☐ Blepharitis _____
- ☐ Cataract _____
- ☐ Contact Lenses _____
- ☐ Corneal Dystrophy _____
- ☐ Diabetic Retinopathy _____
- ☐ Dry Eyes _____
- ☐ Glasses _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Macular Pucker _____
- ☐ Narrow Angles _____
- ☐ Ocular Hypertension _____
- ☐ Ophthalmic Migraine _____
- ☐ Pseudoexfoliation _____
- ☐ Retinal Detachment _____
- ☐ Retinal Tear / Hole _____
- ☐ Strabismus _____
- ☐ Posterior Vitreous Detachment _____
- ☐ Vitreous Floaters _____
- ☐ 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	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment / Disease	☐	☐	☐	_____
Keratoconus	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____