Tozer Eye Center
Randall K. Tozer, M.D.
Eye Physician and Surgeon
Diplomate American Board of Ophthalmology

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____D.O.B. _____

Medical History: Have you had or do you currently have any of the following?

Systemic	**Yes**	**No**
Anemia	❑	❑
Bleeding Disorders	❑	❑
Sickle Cell	❑	❑
Arthritis	❑	❑
Diabetes	❑	❑
Thyroid	❑	❑
Autoimmune Disorders	❑	❑
Dermatitis/Eczema	❑	❑
High Cholesterol	❑	❑

Lungs	**Yes**	**No**
Asthma	❑	❑
Emphysema	❑	❑
Pneumonia	❑	❑

Vascular	**Yes**	**No**
Congestive Heart Failure	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Stroke	❑	❑
Pacemaker	❑	❑

Other	**Yes**	**No**
Cancer	❑	❑
Hepatitis	❑	❑
Tuberculosis	❑	❑
HIV/AIDS	❑	❑
Seizures	❑	❑
Shingles (Zoster)	❑	❑
Herpes Simplex	❑	❑
Neurological	❑	❑
Stomach/Intestinal Disease	❑	❑
Pregnant (Currently)	❑	❑

Eye History	**Yes**	**No**
Cataract	❑	❑
Corneal Diseases	❑	❑
Glaucoma	❑	❑
Lazy Eye (Amblyopia)	❑	❑
Retinal Disease	❑	❑
Eye Surgery	❑	❑

List surgeries: _____

_____

_____

Do you use eye drops? Yes ❑ No ❑

Name of drops _____

Has a family member had any the following?

Glaucoma Yes ❑ No ❑ Macular Degeneration Yes ❑ No ❑ Other Hereditary Eye Disorders Yes ❑ No ❑

Social History:

Do you Smoke? Yes ❑ No ❑ Alcoholic beverage use? Yes ❑ No ❑ Recreational drug use? Yes ❑ No ❑

Pharmacy Information:

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address:_____

List Medications: _____

_____

_____

List Allergies: _____

_____

_____

_____ _____ _____

Patient Signature Staff Signature Date