MEDICAL HISTORY FORM

Date: _____

PATIENT NAME: _____ **D.O.B.** _____

MEDICAL HISTORY: Have you had any of the following?

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

Lungs	Yes	No
Asthma	❑	❑
Emphysema or COPD	❑	❑
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)	❑	❑
Cold Sores (Herpes Simplex)	❑	❑
Neurological	❑	❑
Stomach/Intestinal Disease	❑	❑
Pregnant (Currently)	❑	❑

Eye History	Yes	No
Cataract	❑	❑
Corneal Diseases	❑	❑
Glaucoma	❑	❑
Lazy Eye (Amblyopia)	❑	❑
Retinal Disease	❑	❑
Eye Injury	❑	❑
Prism in Glasses	❑	❑

List Eye 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 ❑ Retinal Detachment Yes ❑ No ❑

Social History:

Have you ever smoked? Yes ❑ No ❑ Alcoholic beverage use? Yes ❑ No ❑ Recreational drug use? Yes ❑ No ❑

MEDICATIONS	List all medications that you are currently taking, including over-the-counter medicines or remedies.				
DRUG NAME	Strength	How Often Used	DRUG NAME	Strength	How Often Used

I have no medical allergies: _____

List Medical Allergies and Reactions: _____

_____

_____ _____ _____

Patient Signature Staff Signature Date