MEDICAL HISTORY

PATIENT NAME:___________________________ ___ __________ **DATE OF BIRTH:**___________ **DATE:**___________

Past Eye History (eye surgery, glaucoma, injuries, etc.):____

____

List any **Eye Medications** you currently take (RX and over the

counter):____

List all **major illnesses (**diabetes, high blood pressure, heart attack, etc.) or **surgeries:** ____________________________

____

Do you have **allergies** to any medications? NO YES please list: ____

____

List any **Medications** you currently take (RX and over the counter):____

____

FAMILY HISTORY **(MOTHER, FATHER, GRANDPARENT, SIBLING)**

Has any member of your family had these diseases? (circle one) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other family disease:____

SOCIAL HISTORY

Do you drink alcohol? YES NO If YES, how much? __________________________

Do you smoke? YES NO If YES, how much? __________________________ How many years?_______________

Caffeine? YES NO If YES, how much? __________________________

Recreational Drugs? YES NO If YES, what type? __________________________

REVIEW OF SYSTEMS

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS/UPDATES
GENERAL / CONSTITUTIONAL (fatigue, fever, night sweats)			
EARS, NOSE, THROAT (hard of hearing)			
RESPIRATORY (cough, wheezing, etc.)			
CARDIOVASCULAR (irregular heartbeat, chest pressure, etc.)			
ENDOCRINE (cold or heat intolerance, excessive thirst, appetite or urination)			
NEUROLOGICAL (dizziness, walking disturbance, headache, etc.)			
SKIN (rash, etc.)			
MUSCLES, BONES, JOINTS (arthritis, joint swelling, muscle weakness, etc.)			
BLOOD / LYMPH (bleeding, bruising, etc.)			
ALLERGIC / IMMUNOLOGIC (environmental allergies, food allergies, etc.).			