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Medical History Form

Patient Name (Please Print): _____ DOB: ____/____/____
Last First MI

Preferred Pharmacy: _____

Medical History

Please list allergies (including medication allergies)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Please list your current medications

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list previous eye injuries, eye surgeries/procedures, or known eye diseases

Please select all that apply to your Medical History

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Lupus/Sjogren's Syndrome |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes- Type: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Condition-Type: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst/Urination | <input type="checkbox"/> Hepatitis- Type: _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Surgery- Type: _____ |
| <input type="checkbox"/> Blood Clots | | <input type="checkbox"/> Cancer- Type: _____ |
| <input type="checkbox"/> Rheumatoid Arthritis | | |

Family History

Has any blood relative ever had the following?

- | | | | |
|---------------------------|-----|----|-----------------|
| Cataracts | Yes | No | Relation: _____ |
| Diabetes | Yes | No | Relation: _____ |
| Glaucoma | Yes | No | Relation: _____ |
| Macular Degeneration | Yes | No | Relation: _____ |
| Retinal Detachment | Yes | No | Relation: _____ |
| Blindness | Yes | No | Relation: _____ |
| Strabismus (Crossed-Eyed) | Yes | No | Relation: _____ |
| Amblyopia (Lazy Eye) | Yes | No | Relation: _____ |

Social History

Have you ever smoked Tobacco? (Circle One) Current Smoker Former Smoker Never Smoker

Review of Systems (Only for patient filling out on the same day of appointment)

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hives | |