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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. _____
2. _____
3. _____
4. _____

Please list your current medications

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

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

_____

_____

Please select all that apply to your Medical History

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

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)*

- ☐ Fatigue
- ☐ Sore Throat
- ☐ Cough
- ☐ Chest Pain
- ☐ Abdominal Pain
- ☐ Blood in Urine
- ☐ Headache
- ☐ Hives
- ☐ Back Pain
- ☐ Seasonal Allergies