

Medical History

Name _____ Date of Birth _____ Date _____

Primary Care Physician _____ Phone _____

Please list any past surgeries, injuries, or hospitalizations _____

Please list any eye surgery or eye injury that you have had _____

Drug Allergies: _____

Allergy	yes	no	Hematologic/Lymph	yes	no
environmental allergies	_____	_____	anemia	_____	_____
Cardiovascular	yes	no	bleed/bruise easily	_____	_____
high blood pressure	_____	_____	Immunologic	yes	no
heart disease	_____	_____	HIV/AIDS	_____	_____
heart attack	_____	_____	Integumentary (Skin)	yes	no
stroke	_____	_____	rash	_____	_____
Constitutional	yes	no	severe acne	_____	_____
fever	_____	_____	Musculoskeletal	yes	no
weight loss	_____	_____	arthritis	_____	_____
fatigue	_____	_____	joint pain	_____	_____
Endocrine	yes	no	Neurological	yes	no
diabetes	_____	_____	seizures	_____	_____
thyroid	_____	_____	Alzheimers/dementia	_____	_____
Gastrointestinal	yes	no	tingling in fingers or toes	_____	_____
colitis	_____	_____	Psychiatric	yes	no
diverticulitis	_____	_____	depression	_____	_____
ulcers	_____	_____	anxiety	_____	_____
liver/hepatitis	_____	_____	Respiratory	yes	no
Genitourinary	yes	no	asthma	_____	_____
kidney problems	_____	_____	tuberculosis	_____	_____
bladder problems	_____	_____	sarcoidosis	_____	_____
prostate problems	_____	_____			
Head/ENT/Dental	yes	no	Current Medications:	_____	_____
hearing loss	_____	_____	_____	_____	_____
sinus problems	_____	_____	_____	_____	_____
recent dental work	_____	_____	_____	_____	_____
Lifestyle Questions	yes	no	_____	_____	_____
smoke	_____	_____	_____	_____	_____
consume alcohol	_____	_____	_____	_____	_____

Family History (Immediate Family only)

Diabetes	Y	N	Strabismus (eye turn)	Y	N	Cataracts	Y	N
Glaucoma	Y	N	Retinal Detachments	Y	N	Macular Degeneration	Y	N