

# 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**: \_\_\_\_\_

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? \_\_\_\_\_

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

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

	YES	NO	DETAILS/UPDATES
<b>GENERAL / CONSTITUTIONAL</b> fever, heat stroke, weight loss, weight gain, usually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>RESPIRATORY</b> congestion, wheezing, short of breath, etc.			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>VASCULAR</b> (circulation, spider veins, reddening of skin, etc.			
<b>GASTROINTESTINAL</b> stomach upset, diarrhea, constipation, hernia, ulcers, etc.			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> are you pregnant? Nursing?			
<b>ENDOCRINE</b> diabetes, hypothyroid, etc.			
<b>NEUROLOGICAL</b> numbness, headache, seizures, paralysis, etc.			
<b>PSYCHIATRIC</b> anxiety, depression, insomnia, etc.			
<b>SKIN</b> pimples, warts, growths, rash, etc.			
<b>MUSCLES, BONES, JOINTS</b> joint pain, stiffness, swelling, cramps, arthritis, etc.			
<b>BLOOD / LYMPH</b> bleeding, high cholesterol, anemia, problems related to blood transfusion, etc.			
<b>ALLERGIC / IMMUNOLOGIC</b> sneezing, swelling, redness, itching, hives, lupus, etc.			