Medical History (YOU)

Do YOU currently have, or have you ever been treated for, any of the following problems or conditions?

- ❑ Allergies
- ❑ Blood/Lymph disorders
- ❑ Cancer
- ❑ Cholesterol
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Digestive/Gastric
- ❑ Ear/Nose/Throat
- ❑ Endocrine
- ❑ Fatigue
- ❑ Fevers
- ❑ Genitourinary
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Immune
- ❑ Integumentary (skin)
- ❑ Kidney
- ❑ Muscle/Bone
- ❑ Neurological/Headache
- ❑ Psychological
- ❑ Respiratory
- ❑ Seizures
- ❑ Sinus
- ❑ Stroke
- ❑ Throat Infections
- ❑ Thyroid
- ❑ Trauma
- ❑ Unusual weight loss/gain

List any previous surgeries and dates____

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Medications

List all CURRENT medications, including OTC and eye drops, with dosages (if possible) OR present list of medications

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____

❑ No Medications

Medication Allergies

List any allergies you may have and reaction

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____

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❑ No Medication Allergies

Family Medical/Eye History

Does anyone in your FAMILY currently have, or has ever been treated for, any of the following problems or conditions?

	Relation
❑ Amblyopia (lazy eye)	____________
❑ Blindness	____________
❑ Cataracts	____________
❑ Color Blindness	____________
❑ Glaucoma	____________
❑ Macular Degeneration	____________
❑ Retinal Disorders	____________
❑ Strabismus (crossed eyes)	____________

	Relation
❑ Autoimmune Disorders	____________
❑ Cancer	____________
❑ Cardiovascular Disease	____________
❑ Diabetes	____________
❑ Heart Disease	____________
❑ High Blood Pressure	____________
❑ Musculoskeletal Disorders	____________
❑ Stroke	____________

Miscellaneous

Women:
Are you pregnant? Yes / No
Are you breastfeeding? Yes / No

Hobbies/Recreational Sports?

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____

____

Social History

Check one that applies

Are you a drug user? ❑Yes ❑No

Are you a: ❑Non-drinker ❑Social drinker

Tobacco Use

Check one that applies

❑Never Smoker ❑Light Tobacco Smoker

❑Former Smoker ❑Heavy Tobacco Smoker

Office use only:

Review Date ____________ Initials ________ Dr. Signature ______________________________

Review Date ____________ Initials ________

Review Date ____________ Initials ________