Medical History

Name: Mrs./Ms./Miss/Mr./Dr.___________________________ Date: ___________
Address: ____
____ D.O.B.__________

Have you had any of the following? (explain **YES** answers below)

Glasses or contacts	Yes	No	
Laser eye surgery	Yes	No	
Cataract surgery	Yes	No	
Other eye surgery	Yes	No	
Other eye problems	Yes	No	

Do you have any of the following conditions? Please circle **YES** or **NO**
(explain **YES** answers below)

Fever or chills	Yes	No	
Recent weight change	Yes	No	
Fatigue or overall weakness	Yes	No	
Rash or skin problems	Yes	No	
Sinus trouble	Yes	No	
Mouth sores or disease	Yes	No	
Lung disease	Yes	No	
Heart disease	Yes	No	
High blood pressure	Yes	No	
Stomach or intestinal problem	Yes	No	
Liver disease	Yes	No	
Diabetes	Yes	No	
Thyroid disease	Yes	No	
Kidney problem	Yes	No	
Arthritis	Yes	No	
Back or neck pain	Yes	No	
Anemia	Yes	No	
Bleeding disorder	Yes	No	
Infectious disease	Yes	No	
Stroke/neurological disorder	Yes	No	
Depression/psychiatric problem	Yes	No	

Date of your most recent physical examination_____________________________
Who is your primary physician? Name: ________________________________
City, State: ______________________________

(CONTINUED ON OTHER SIDE)

List any other major illnesses, hospitalizations, and surgeries (with dates if possible).

List all medications you currently take (name, dosage, frequency). If none, check here__

Eye medications:

Other medications:

Are you allergic to any medications? Yes No If YES, please list:

Have any family members or relatives had any of the following conditions?
(relationship to you below)

Condition			
Cataract	Yes	No	
Glaucoma	Yes	No	
Macular Degeneration	Yes	No	
Retinal Detachment	Yes	No	
Diabetic retinopathy	Yes	No	
Blindness	Yes	No	
Diabetes	Yes	No	
Heart disease	Yes	No	
Cancer	Yes	No	

Your occupation:		
Can you read small print (newsprint)?	Yes	No
Do you smoke tobacco	Yes	No
Do you drink alcohol	Yes	No

FOR OFFICE USE ONLY

__ I have reviewed this medical history.

__ I have made additions to this medical history as noted on the exam form.

_________________________________ Date: ______________________