

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL.

Patient Name:				
Last Name	First Name	Middle		
Date of Birth://	Marital Status: Married	Single Divorced Widowed		
Eye Doctor's Name:				
Date of Last Visit w/ Eye Doctor:	Reason for Visit:			
FAMILY DOCTOR:	Phone: ()			
Nam	e			
Address:Street	City	State Zip		
Please check anything listed below if you are experiencing current symptoms. Please also note which eye: right eye (R), left eye (L), or both eyes (B).				
\Box Cataract(s) - \Box R \Box L \Box B		\square Macular Degeneration - \square R \square L \square B		
☐Contact lenses	□Narrow Angles - □R □L □B			
\Box Corneal Dystrophy - \Box R \Box L \Box B	\square Ocular Hypertension - \square R \square L \square B			
\square Diabetic retinopathy - \square R \square L \square B	☐Ocular Migraine			
\square Dry eye(s) - \square R \square L \square B	\square Pink eye - \square R \square L \square B			
\square Floaters - \square R \square L \square B	\square Retinal Tear - \square R \square L \square B			
□Glasses	\square Strabismus - \square R \square L \square B			
\square Glaucoma - \square R \square L \square B	Other:			
Eye Surgery: Please Check all that apply. Please also note which eye: right eye (R), left eye (L), or both eyes (B).				
\square Blepharoplasty - \square R \square L \square B	\Box LASIK - \Box R \Box	\square LASIK - \square R \square L \square B		
\square Cataract surgery - \square R \square L \square B	\square PRK - \square R \square L	\square PRK - \square R \square L \square B		
\square Corneal transplant - \square R \square L \square B	□Punctual Plugs	\square Punctual Plugs - \square R \square L \square B		
\square Eye injections - \square R \square L \square B	□Ptosis repair - □	□Ptosis repair - □R □L □B		
\Box Laser-narrow angles- \Box R \Box L \Box B	□Retinal laser - [\square Retinal laser - \square R \square L \square B		
\square Laser-open angles- \square R \square L \square B	\Box YAG Laser capsulotomy - \Box R \Box L \Box B			
Other:				
WOMEN: ARE YOU?				
No Yes No Yes				
□ □ Pregnant/Trying to get pregnant □ □ Nursing				

PAST/PRESENT MEDICAL HISTORY:			
No Yes	No Yes	No Yes	
□ □Alzheimer's	□ □Eczema	□ □Migraine	
□ □Anemia	□ □Epilepsy	\square \square MRSA	
	□ □Fibromyalgia	□ □Phlebitis	
☐ ☐ Arthritis	☐ ☐Heart Disease	□ □Pneumonia	
□ □ Asthma	□ □Hernia	☐ ☐Psychiatric Disorder	
☐ ☐Bronchitis	☐ ☐ High Cholesterol	☐ ☐Radiation/Chemo	
	☐ ☐ High Blood Pressure	☐ ☐Rheumatic Fever	
□ □Claustrophobia	☐ ☐Irregular Heartbeat/pacer	☐ ☐Sleep apnea	
☐ ☐Congestive Heart Failure	☐ ☐Kidney Disease	□ □Stroke	
	□ □Leukemia	☐ ☐Thyroid Disorder	
☐ ☐ Diabetes Type	□ □Lymphoma	□ □Tuberculosis	
☐ ☐ Diverticulosis	☐ ☐Liver Disease/Hepatitis	□ □Ulcers	
Other:	•		
HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.			
No Yes	No Yes	No Yes	
□ □Appendectomy		_ □ □Mastectomy	
□ □ Back			
□ □Cancer	☐ ☐Hysterectomy	□ □ Stomach/Abdomen	
□ □Eye Surgery	_	\Box \Box Thyroid/Neck	
☐ ☐Gallbladder	Other:		
CURRENT PERSCRIPTIONS & NON-PRESCRIPTION MEDICATIONS: Please list name, dose and frequency or attach a list:			
ALLERGIES TO MEDICATIONS: □ No Known Allergies Latex Sensitivity: □No □Yes Please list below or attach a list:			
FAMILY HISTORY: Living? Medical Problems or Cause of Death			
No Yes Mother □ □			
Father \Box			
Brother/Sister			
SOCIAL HISTORY: Do (did) you?			
No Yes Former	Hannan ala 40	Earland manuscrip	
		For how many years?	
□ □ □ Drink Alcohol	How much per day?		
\square \square Rec. Drug Use	How much per day?	_	