MEDICAL HISTORY

Patient name_____ Date form completed_____

Allergies to medication and the type of reaction it causes: _____

_____

Primary Care doctor: _____

Primary eye care provider:_____

Medical History: Check all that apply and write in dates if known

☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Heart Attack
☐ Irregular Heart Beat
☐ High Cholesterol
☐ Asthma
☐ Emphysema
☐ Sleep Apnea
☐ COPD
☐ Diabetes
☐ Cancer (type:_____)
☐ Thyroid under/over active
☐ Graves Disease
☐ Bell's palsy (right / left)
☐ Seizures
☐ Arthritis
☐ Kidney Disease (type:_____)
☐ Liver Disease (type:_____)
☐ Environmental Allergies
☐ Blood Disorders (type:_____)
☐ Anxiety
☐ Depression
☐ Alzheimer's

Eye History:

☐ Cataract
☐ Glaucoma
☐ Retinal Detach
☐ Macular Degen
☐ Diab Retinopathy
☐ Crossed Eye
☐ Lazy Eye
☐ Injury (what, when)

☐ **No Medical Problems**

☐ Other medical problems:_____

_____

Surgery: List all Surgeries you have had, including general surgery, eye surgery, facial surgery or any other, including the Year

_____

_____

_____

_____

Family History: Check all that Apply ☐ **No Family HX**

☐ Droopy lids ☐ Cancer ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes

☐ Blindness ☐ Unexplained Vision Loss ☐ Heart Disease

Social History:

Do you smoke? ☐yes ☐No Alcohol? ☐Yes ☐No Drugs? ☐Yes ☐No

Are you or could you possibly be pregnant? ☐Yes ☐No

List of your current medications, including over the counter medications:

_____

_____

_____

_____

_____

_____