MEDICAL HISTORY FORM

Name: _____ **Date:_____**

Current eye problem: _____
_____

REVIEW OF **CURRENT** HEALTH:	YES	NO	DETAILS
GENERAL (fever, weight loss, malaise…)	___	___	_____
EAR/NOSE/THROAT (stuffy nose, ear ache, cough, dry mouth…)	___	___	_____
CARDIOVASCULAR (chest pain, racing pulse…)	___	___	_____
RESPIRATORY (congestion, wheezing…)	___	___	_____
GASTROINTESTINAL (stomach upset, diarrhea, constipation)	___	___	_____
GENITOURINARY (urinary flow problems)	___	___	_____
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling)	___	___	_____
SKIN (rashes, suspicious growths)	___	___	_____
NEUROLOGICAL (headache, numbness, paresthesias)	___	___	_____
PSYCHIATRIC (depression, anxiety)	___	___	_____
ENDOCRINE (hot/cold intolerance)	___	___	_____
HEMATOLOGIC (bleeding disorder, anemia)	___	___	_____
ALLERIC/IMMUNOLOGIC (sneezing, swollen nodes, hives)	___	___	_____

*****Please provide the following information if NOT registered on line through our portal:**

Medications you currently take:

_____
_____
_____

Allergies to medications:

___ NONE; IF YES, please list: _____

List all major illnesses: _____
_____

List any surgeries you have had:_____

Family History	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Glaucoma	___	___	___	___	___	___	___	___
Macular degeneration	___	___	___	___	___	___	___	___
Retinal detachment	___	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___
Thyroid disease	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___
Other	___	___	___	___	___	___	___	___

Social History

Smoking: ___ never smoker
___ current smoker (___ packs per day)
___ former smoker (___ pack years)

Alcohol: ___ Yes ___ No; If yes, how much per week? _____

Drug use: ___ Yes ___ No