Medical History

Name:_____ **Date of Birth:**_____

Family doctor or primary medical professional _____

Name of doctor or person who referred you here (if applicable) _____

Past History

Do you have diabetes?	**Yes**	**No**	If yes, how many years?_____
Do you have high blood pressure?	**Yes**	**No**	If yes, how many years?_____
Have you ever had a stroke?	**Yes**	**No**	if yes, what year?_____
Have you ever had a heart attack?	**Yes**	**No**	if yes, what year?_____
Have you ever had cancer?	**Yes**	**No**	If yes, what kind/when? _____

List all medical illnesses or injuries_____

_____

_____

_____

_____

List any medication you currently take including aspirin and over-the-counter medicines. _____

_____

_____

_____

_____

List any previous surgeries. _____

_____

Are you allergic to any medications? Yes No If yes, list medicine allergies _____

Social history: Occupation _____

Do you smoke? **Yes** **No** If yes, how many packs a day? _____

Do you drink alcohol? **Yes** **No** If yes, how many drinks a day? _____

Family History			Relationship to the Patient
Glaucoma	**Yes**	**No**	_____
Diabetes	**Yes**	**No**	_____
Cataract	**Yes**	**No**	_____
Amblyopia (lazy eye)	**Yes**	**No**	_____
Macular Degeneration	**Yes**	**No**	_____
Heart disease/Stroke at young age	**Yes**	**No**	_____

Systems Review				If yes, please explain:
Have you had:	fever/weight loss?	**Yes**	**No**	_____
	ear, nose, throat problems?	**Yes**	**No**	_____
	heart disease/murmur?	**Yes**	**No**	_____
	chronic bronchitis/COPD?	**Yes**	**No**	_____
	asthma?	**Yes**	**No**	_____
	stomach/intestine problems?	**Yes**	**No**	_____
	muscle/joint pains/arthritis?	**Yes**	**No**	_____
	skin problems/rash?	**Yes**	**No**	_____
	neurologic problems?	**Yes**	**No**	_____
	thyroid disease?	**Yes**	**No**	_____
	seasonal allergy?	**Yes**	**No**	_____
	psychiatric problems?	**Yes**	**No**	_____

Dr. Signature:_____ Date:_____