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____

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____

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

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____

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:________________