· CHIPPEWA VALLEY ·
EYE CLINIC
2525 COUNTY HWY I
CHIPPEWA FALLS, WI 54729

# 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, how many years? | _____ |
| Have you ever had a heart attack? | ☐ Yes ☐ No | If yes, how many years? | _____ |
| Have you ever had cancer? | ☐ Yes ☐ No | If yes, how many years? | _____ |

List all Medical Illnesses or Injuries _____

List Any Medications 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:

| | | | |
|---|---|---|---|
| Glaucoma | ☐ Yes ☐ No | Relationship to Patient | _____ |
| Diabetes | ☐ Yes ☐ No | Relationship to Patient | _____ |
| Cataract | ☐ Yes ☐ No | Relationship to Patient | _____ |
| Amblyopia (lazy eye) | ☐ Yes ☐ No | Relationship to Patient | _____ |
| Macular Degeneration | ☐ Yes ☐ No | Relationship to Patient | _____ |
| Heart Disease/Stroke at Young Age | ☐ Yes ☐ No | Relationship to Patient | _____ |

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# MEDICAL HISTORY

| SYSTEMS REVIEW \| HAVE YOU HAD: | | | If yes, please explain |
|---|---|---|---|
| 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 | |
| Neurological Problems? | ☐ Yes | ☐ No | |
| Thyroid Disease? | ☐ Yes | ☐ No | |
| Seasonal Allergy? | ☐ Yes | ☐ No | |
| Psychiatric Problems? | ☐ Yes | ☐ No | |

**DR. SIGNATURE:** _____ **DATE:** _____