MEDICAL HISTORY FORM

NAME: ____ **BIRTHDATE:** _____/_____/_____ **DATE:** __________

REASON FOR YOUR VISIT: Please describe. ____

____

MEDICAL HISTORY:
Select any of the following conditions that you currently have, and when you were diagnosed:

Are you currently pregnant? ☐ YES

☐ Anxiety ____________________________
☐ Arthritis ___________________________
☐ Asthma ____________________________
☐ Atrial Fibrillation ____________________
☐ Bone Marrow Transplant _______________
☐ BPH ______________________________
☐ Cancer ____________________________
☐ COPD _____________________________
☐ Coronary Heart Disease _______________
☐ Depression _________________________
☐ Diabetes ___________________________
☐ End Stage Kidney Disease ______________
☐ GERD _____________________________
☐ Headaches _________________________
☐ Hearing Loss ________________________
☐ Hepatitis ___________________________
☐ HIV / AIDS _________________________
☐ Hypercholesterolemia __________________
☐ Hypertension ________________________
☐ Leukemia __________________________
☐ Lymphoma _________________________
☐ Radiation Treatment __________________
☐ Seizures ___________________________
☐ Stroke _____________________________
☐ Thyroid Disorder _____________________
☐ Other _____________________________
☐ **None of these apply**

PAST SURGERIES: Have you had any surgeries? If yes, please list what procedure and date of surgery:

____

____

OCULAR HISTORY:
Select any of the following conditions that you current have, which eye and when you were diagnosed:

☐ Allergic Conjunctivitis _________________
☐ Amblyopia / Lazy Eye _________________
☐ Blepharitis __________________________
☐ Cataract ____________________________
☐ Contact Lenses _______________________
☐ Corneal Dystrophy ____________________
☐ Diabetic Retinopathy ___________________
☐ Dry Eyes ____________________________
☐ Glasses _____________________________
☐ Glaucoma ___________________________
☐ Macular Degeneration __________________
☐ Macular Pucker _______________________
☐ Narrow Angles _______________________
☐ Ocular Hypertension ___________________
☐ Ophthalmic Migraine ___________________
☐ Pseudoexfoliation _____________________
☐ Retinal Detachment ___________________
☐ Retinal Tear / Hole ____________________
☐ Strabismus __________________________
☐ Posterior Vitreous Detachment __________
☐ Vitreous Floaters _____________________
☐ Other _______________________________
☐ **None of these apply**

PAST SURGERIES: Have you had any eye surgeries? If yes, please list what procedure, which eye and date of surgery:

____

____

MEDICATIONS:
List any current medications (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

ALLERGIES: List any **medication** or **environmental** allergies:

____

SOCIAL HISTORY: *This information is kept strictly confidential*
☐ I prefer to discuss my social history information directly with my doctor. (Check box)

Smoking Status: ☐ Non-smoker ☐ Current every day ☐ Current some days

☐ Cigar smoker ☐ Tobacco smoker ☐ How much (pk/day) ________

☐ Former smoker, date quit: _____________________ ☐ Total years smoking ________

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long ________________________________
Do you do illegal drugs ☐ No ☐ Yes If yes, type/amount/how long ________________________________
Do you drive? ☐ No ☐ Yes ☐ Daytime ☐ Nighttime

FAMILY HISTORY:
Please indicate any family history (parents, grandparents, siblings or children; living or deceased) for the following conditions:

DISEASE/CONDITION	**NO**	**YES**	**?**	**RELATIONSHIP TO YOU**
Amblyopia / Lazy Eye	☐	☐	☐	____________________
Blindness	☐	☐	☐	____________________
Cataract	☐	☐	☐	____________________
Crossed Eyes	☐	☐	☐	____________________
Glaucoma	☐	☐	☐	____________________
Macular Degeneration	☐	☐	☐	____________________
Retinal Detachment / Disease	☐	☐	☐	____________________
Keratoconus	☐	☐	☐	____________________
Arthritis	☐	☐	☐	____________________
Cancer	☐	☐	☐	____________________
Diabetes	☐	☐	☐	____________________
Heart Disease	☐	☐	☐	____________________
High Blood Pressure	☐	☐	☐	____________________
Kidney Disease	☐	☐	☐	____________________
Lupus	☐	☐	☐	____________________
Thyroid Disease	☐	☐	☐	____________________
Other _____________________	☐	☐	☐	____________________