Name: _____ Date:_____

Patient Medical History Record

Please answer the following questions about your medical status and history:

1) List the **Medications** you are currently taking, if any (include aspirin, vitamins, supplements): _____

_____

_____(Continue on back if needed.)

2) Allergies: Do you have any food or drug allergies (including latex, adhesives, shellfish or iodine)? □ YES □ NO

If Yes, please list allergies and reaction(s).____

_____(Continue on back if needed.)

3) Have you ever been diagnosed with any **Ocular Problems** (e.g., Glaucoma, Cataract, Macular Degeneration, other)? □ YES □ NO If Yes, please list: _____

4) Have you ever had any **Ocular Procedures** (e.g., Cataract surgery, Glaucoma surgery, Retinal surgeries, Lasik, RK, other)? □ YES □ NO If Yes, please list:_____

5) Have you ever had any **general surgeries/procedures** (e.g., Gallbladder, Cardiac, Pacemaker, Appendix, other)? □ YES □ NO If Yes, please list:_____

_____

REVIEW OF SYSTEMS: Please check all conditions that you have.		**PLEASE PROVIDE EXPLANATION**
Diabetes	□	
Cancer	□	
High Cholesterol	□	
High Blood Pressure	□	
Chronic fever, unexpected weight loss/gain, fatigue	□	
Skin (e.g., rashes, excessive dryness, rosacea, skin cancer)	□	
Ear/nose/throat (e.g., hearing loss, sinus problems, sore throat, chronic cough)	□	
Respiratory (e.g., asthma, emphysema, COPD, shortness of breath)	□	
Cardiovascular (e.g., heart disease, chest pain, irregular heart beat)	□	
Gastrointestinal (e.g., heart burn, ulcer, abdominal pain, diarrhea, vomiting)	□	
Urinary (e.g., kidney/bladder conditions, pain or discomfort, blood in urine)	□	
Musculoskeletal (e.g., arthritis, muscle aches, joint pain, swollen joints)	□	
Neurologic (e.g., stroke, numbness, awakeness, headaches, paralysis)	□	
Endocrine (diabetes, thyroid)	□	
Psychiatric (e.g., depression, anxiety, panic attacks)	□	
Autoimmune (e.g., lupus, rheumatoid arthritis, HIV/AIDS, hepatitis)	□	
Environmental Allergies	□	

Race Association: □ White □ Black □ Hispanic □ Asian □ Indian □ Other _____

Family History

Have your parents, grandparents or siblings been treated for any of the following? If Yes, please specify who.

Glaucoma _____ Macular Degeneration _____ Heart Disease _____

Diabetes _____ Retinal Detachment _____ Cancer _____

Blindness _____ Unexplained Vision Loss _____

Social History

Do you drink alcohol? □ YES □ NO Are you pregnant? □ YES □ NO

Do you smoke? □ YES □ NO Former Smoker? □ YES □ NO