Patient Medical History

Name: _____ DOB: _____

Primary Care Physician Name: _____Phone:_____

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Primary Care Physician Address: _____

Pharmacy: _____Location (street & city):_____

Please mark all that apply:

Overall Healthy		Retinal Detachment		Bell's Palsy		Kidney Disease	
Amblyopia (Lazy Eye)		AIDS/HIV		Bleeding Disorder		Kidney Stones	
Aphakia		Diabetes		Cancer		Liver Disease	
Astigmatism		Graves Disease		Chicken Pox		Lung Disease	
Cataracts		Herpes		Congestive Heart Failure		Meningitis	
Diabetic Retinopathy		HIV Positive		Crohn's Disease		Migraine	
Double Vision		Hypertension		COPD		MRSA	
Dry Eyes		Hypothyroidism		Dermatitis		Polymyalgia	
Flashes		Hyperthyroidism		Eczema		Psychiatric Disorder	
Floaters		Lupus		Emphysema		Shingles	
Glaucoma		Multiple Sclerosis		Epilepsy		Skin Cancer	
Hyperopia (far sighted)		Rheumatoid Arthritis		Fibromyalgia		Stroke	
Iritis		Sjogrens		Hearing Loss		Syphilis	
Keratoconus		Anemia		Heart Disease		Toxoplasmosis	
Macular Degeneration		Arthritis		Hepatitis		Tuberculosis (TB)	
Myopia (Near sighted)		Arrhythmia		High Cholesterol		Vertigo	
Optic Neuritis		Asthma		Histoplasmosis		Other	

Current Medications: _____

Please List All Medications You Are Allergic To: _____

Family History for First Degree Relatives (parent, child, sibling) Please mark all that apply

Arthritis		Diabetes		Kidney Disease		Stroke	
Blindness		Glaucoma		Lazy Eye		TB	
Cancer		Heart Disease		Macular Degeneration			
Cataracts		High Blood Pressure		Retinal Disease			

Ocular Surgeries (please mark all that apply)

No prior ocular surgery		Foreign Body Removal		RK	
Blepharoplasy		Retinal Laser Surgery		Strabismus Surgery	
Cataract Surgery		LASIK/PRK		Trabeculectomy (Glaucoma Surgery)	
Corneal Transplant		Punctal Plugs		Vitrectomy	

Social History: Circle Y or N

Alcohol Use: Y N
Tobacco Use: Y N
Computer Use: Y N If yes, how many hours a day do you use computer? _____
Are you Pregnant? Y N If yes, when is your due date? _____

The above information is true to the best of my knowledge.

Signature: _____Date:_____