Date:

Name:

Chart# DOB:

Sex: ❑ M ❑ F

Patient Medical History Record

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

1) List the medications you use, if any (including aspirin, vitamins / supplements): ______

______

2) **Allergies:** Do you have any food or drug allergies (including latex, adhesive, shellfish, iodine)? ❑ YES ❑ NO
If Yes, please list: ______

3) Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or lazy eye, retinal detachment, macular degeneration, diabetes, cornea)? ❑ YES ❑ NO If yes please explain: ______

______

4) If you wear glasses or contact lenses, how long have you had your current prescription? ______

5) Do you have any glare or light sensitivity (day/night)? ❑ YES ❑ NO If yes please explain: ______

6) Have you had any surgery/hospitalization in the last five years? ❑ YES ❑ NO If yes, please provide date and reason:

Date: / / Reason: ______

Date: / / Reason:

REVIEW OF SYSTEMS: Please check all conditions that you have or that you take medication for:

Check the box for yes, or leave blank for no		**PLEASE PROVIDE EXPLANATION**
High cholesterol……………………………………………	❑	______
High blood pressure…………………………………………	❑	______
Cardiovascular (e.g. heart disease, chest pain, irregular heart beat)………..	❑	______
Endocrine (diabetes, thyroid)…………………………………….	❑	______
Chronic fever, unexpected weight loss/gain, fatigue………….	❑	______
Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat, chronic cough)	❑	______
Respiratory (e.g. asthma, emphysema)……………………………	❑	______
Gastrointestinal (e.g.heartburn, ulcer, abdominal pain, diarrhea, vomiting)……	❑	______
Urinary (e.g. kidney/bladder conditions, pain or discomfort, blood in urine)	❑	______
Skin (e.g. rashes, excessive dryness, rosacea, skin cancer)………	❑	______
Musculoskeletal (e.g. arthritis, muscle aches, joint pain, swollen joints)	❑	______
Neurologic (e.g. stroke, numbness, weakness, headaches, paralysis)	❑	______
Psychiatric (e.g. depression, anxiety)………………………………	❑	______
Autoimmune deficiency (e.g. lupus, rheumatoid arthritis, HIV, hepatitis)	❑	______
Cancer…………………………………………………………………	❑	______
Other………………………………………………………………..	❑	

FAMILY HISTORY

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

❑ Diabetes ______ ❑ Stroke ______ ❑ Cancer ______
❑ High Blood Pressure ______ ❑ Macular Degeneration ______ ❑ Any Other ______
❑ Heart Disease ❑ Glaucoma

SOCIAL HISTORY

Do you drink alcohol? Yes ❑ No ❑ **If yes:** ❑ Occasional ❑ 1 per day ❑ 2-3 per day ❑ 4+ per day
Do you smoke? Yes ❑ No ❑ **If yes:** ❑ Occasional ❑ 1/2 pk/day ❑ 1 pk/day ❑ 1+ pk/day
What year did you start smoking_____ When did you quit smoking_______
Current Height: ______ ft. ______ in. Current Weight: ______lbs.
Women: Are you currently pregnant? Yes ❑ No ❑

Patient Signature: ______ **Date:** ______ **Initials:** ______