Medical/Eye History

Name _____ Birth Date _____

Medical Dr. _____ Pharmacy _____

Do YOU have any of the following (if so, please circle and explain)?

Genitourinary problems (bladder/Kidney) _____
Ear/Nose/Throat problems _____
Gastrointestinal problems _____
Musculoskeletal disorders _____
Heart Disease _____
Blood Disorders (anemia) _____
Allergies _____
Breathing problems (asthma/COPD) _____
Neurological disorders (MS/migraines) _____
Skin diseases (rosacea/eczema) _____
Psychiatric disorders (anxiety/depression) _____
Endocrine disorders (diabetes/thyroid) _____
Other _____

What, if any, medications are you allergic to?_____

Do you drive? _____YES _____NO Do you use tobacco? _____YES_____NO

Do you use recreational drugs?_____YES_____NO Do you use alcohol? _____YES_____NO

Have you ever had surgery? (if so, explain) _____

Have you ever been hospitalized? (if so, explain)_____

Have you ever had eye surgery? (if so, explain) _____

Are you pregnant?_____YES_____NO

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

- Diabetes _____
- High Blood Pressure _____
- Heart Disease _____
- Stroke _____
- Lung Disease _____
- Thyroid Disease_____
- Cancer (what type?) _____

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

- Cataracts _____
- Glaucoma _____
- Macular Degeneration _____
- Lazy Eye _____
- Dry Eye _____
- Diabetic Retinopathy _____
- Blepharitis _____

Please list all medications, including over-the-counter products, vitamins and nutritional supplements

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