**Tozer Eye Center**
**Randall K. Tozer, M.D.**
Eye Physician and Surgeon
*Diplomate American Board of Ophthalmology*

# MEDICAL HISTORY FORM

Date: _____

Patient Name: _____D.O.B. _____

**Medical History:** Have you had or do you currently have any of the following?

| **Systemic** | **Yes** | **No** |
|---|---|---|
| Anemia | ❑ | ❑ |
| Bleeding Disorders | ❑ | ❑ |
| Sickle Cell | ❑ | ❑ |
| Arthritis | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Thyroid | ❑ | ❑ |
| Autoimmune Disorders | ❑ | ❑ |
| Dermatitis/Eczema | ❑ | ❑ |
| High Cholesterol | ❑ | ❑ |

| **Lungs** | **Yes** | **No** |
|---|---|---|
| Asthma | ❑ | ❑ |
| Emphysema | ❑ | ❑ |
| Pneumonia | ❑ | ❑ |

| **Vascular** | **Yes** | **No** |
|---|---|---|
| Congestive Heart Failure | ❑ | ❑ |
| Heart Disease | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Stroke | ❑ | ❑ |
| Pacemaker | ❑ | ❑ |

| **Other** | **Yes** | **No** |
|---|---|---|
| Cancer | ❑ | ❑ |
| Hepatitis | ❑ | ❑ |
| Tuberculosis | ❑ | ❑ |
| HIV/AIDS | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| Shingles (Zoster) | ❑ | ❑ |
| Herpes Simplex | ❑ | ❑ |
| Neurological | ❑ | ❑ |
| Stomach/Intestinal Disease | ❑ | ❑ |
| Pregnant (Currently) | ❑ | ❑ |

| **Eye History** | **Yes** | **No** |
|---|---|---|
| Cataract | ❑ | ❑ |
| Corneal Diseases | ❑ | ❑ |
| Glaucoma | ❑ | ❑ |
| Lazy Eye (Amblyopia) | ❑ | ❑ |
| Retinal Disease | ❑ | ❑ |
| Eye Surgery | ❑ | ❑ |

List surgeries: _____

_____

_____

Do you use eye drops? Yes ❑ No ❑

Name of drops _____

Has a family member had any the following?

Glaucoma Yes ❑ No ❑ Macular Degeneration Yes ❑ No ❑ Other Hereditary Eye Disorders Yes ❑ No ❑

**Social History:**

Do you Smoke? Yes ❑ No ❑ Alcoholic beverage use? Yes ❑ No ❑ Recreational drug use? Yes ❑ No ❑

**Pharmacy Information:**

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address:_____

List Medications: _____

_____

_____

List Allergies: _____

_____

_____

_____ _____ _____

Patient Signature Staff Signature Date