Medical History Form

Name:_____**Date of Birth:**_____**Date:**_____

Address:_____**City:**_____**State:**___**Zip:**_____

Phone:_____**Last Eye Exam:**_____**Occupation:**_____

Do you have any history of or surgery for the following?

Review of Systems	**Yes**	**No**	**If yes, please describe**
1. Fever, weight loss(Constitutional)			
2. Ears, nose, mouth or throat			
3. Heart, blood pressure, stroke(Cardiovascular)			
4. Asthma, Emphysema, TB(Respiratory)			
5. Ulcers, Hepatitis, Reflux(Gastrointestinal)			
6. Bladder, Kidney, Prostate(Genitourinary)			
7. Arthritis, Osteoporosis(Musculoskeletal)			
8. Skin, Breast(Integumentary)			
9. Alzheimer's, Parkinson's Disease(Neurologic)			
10. Depression, anxiety, dementia(Psychiatric)			
11. Diabetes, thyroid, grave's disease(Endocrine)			
12. Anemia, cholesterol(Hematologic, Lymphatic)			
13. Lupus, HIV, herpes(Allergic, Immunologic)			
14. Irritable bowel, Crohn's Disease(Digestive)			
15. Pregnant, menopause(Reproductive)			

Social History (Circle if used regularly and describe frequency)

Recreational drugs, Alcohol, Tobacco_____

List all current medications and supplements:_____

_____

_____

_____

_____

List any drug allergies and reaction_____

_____

_____

Past Eye History **Yes** **No** **Describe**

1. **Injury/Surgery/Laser**_____
2. **Cataracts**_____
3. **Glaucoma**_____
4. **Macular Degeneration**_____
5. **Lazy Eye**_____
6. **Flashes/Floaters**_____
7. **Double Vision, Prism**_____
8. **Contact lenses**_____
9. **Dry eyes, corneal scarring**_____
10. **Other eye problems**_____

Significant Family History **Yes** **No** **Describe**

1. **Diabetes**_____
2. **Blood Pressure, Heart**_____
3. **Macular Degeneration**_____
4. **Glaucoma**_____
5. **Cancer**_____
6. **Blindness**_____
7. **Lazy Eye**_____
8. **Other Eye Problems**_____