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: _____

REVIEW OF SYSTEMS: Please check all conditions that you have:		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, rheumatiod arthritis, HIV, hepatitis)	❑	
Cancer……	❑	

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

OCCUPATION: _____

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

Any additional comments: _____

Patient Signature: _____ **Date:** _____

Date	Initials	Date	Initials	Date	Initials	Date	Initials