MEDICAL HISTORY

Patient name_____________________________ Date form completed____________

Allergies to medication and the type of reaction it causes: ______________________

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Primary Care doctor: ____

Primary eye care provider:____

Medical History: Check all that apply and write in dates if known

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Irregular Heart Beat
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ COPD
- ☐ Diabetes
- ☐ Cancer (type:____________)
- ☐ Thyroid under/over active
- ☐ Graves Disease
- ☐ Bell's palsy (right / left)
- ☐ Seizures
- ☐ Arthritis
- ☐ Kidney Disease (type:____________)
- ☐ Liver Disease (type:______________)
- ☐ Environmental Allergies
- ☐ Blood Disorders (type:_____________)
- ☐ Anxiety
- ☐ Depression
- ☐ Alzheimer's

Eye History:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Retinal Detach
- ☐ Macular Degen
- ☐ Diab Retinopathy
- ☐ Crossed Eye
- ☐ Lazy Eye
- ☐ Injury (what, when)

☐ **No Medical Problems**

☐ Other medical problems:____

____

Surgery: List all Surgeries you have had, including general surgery, eye surgery, facial surgery or any other, including the Year

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Family History: Check all that Apply ☐ **No Family HX**

☐ Droopy lids ☐ Cancer ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes

☐ Blindness ☐ Unexplained Vision Loss ☐ Heart Disease

Social History:

Do you smoke? ☐yes ☐No Alcohol? ☐Yes ☐No Drugs? ☐Yes ☐No

Are you or could you possibly be pregnant? ☐Yes ☐No