Patient Medical History Information

Please bring completed form to your appointment unless you have submitted electronically

Name:		Date of Birth:	
Referring Doctor:		Eye Doctor:	
PCP Name and Phone:			
MEDICAL HISTORY	*Do you now or have you ever had:*		
Heart Disease	☐ **Yes** ☐ **No**	Type 1 Diabetes	☐ **Yes** ☐ **No**
Hypertension	☐ **Yes** ☐ **No**	Type 2 Diabetes	☐ **Yes** ☐ **No**
Alzheimer's	☐ **Yes** ☐ **No**	Hypo Thyroid disease	☐ **Yes** ☐ **No**
Dementia	☐ **Yes** ☐ **No**	Hyper Thyroid disease	☐ **Yes** ☐ **No**
Stroke/Mini Stroke	☐ **Yes** ☐ **No**	Hepatitis	☐ **Yes** ☐ **No**
Kidney disease	☐ **Yes** ☐ **No**	HIV	☐ **Yes** ☐ **No**
Dialysis	☐ **Yes** ☐ **No**	Herpes Simplex	☐ **Yes** ☐ **No**
Rheumatoid Arthritis	☐ **Yes** ☐ **No**	Shingles	☐ **Yes** ☐ **No**
Anemia	☐ **Yes** ☐ **No**	Tuberculosis	☐ **Yes** ☐ **No**
High Cholesterol	☐ **Yes** ☐ **No**	Asthma	☐ **Yes** ☐ **No**
Blood Thinners	☐ **Yes** ☐ **No**	COPD	☐ **Yes** ☐ **No**
PAST SURGICAL PROCEDURES			
Heart Bypass	☐ **Yes** ☐ **No**	Joint Replacement ☐ **Yes** ☐ **No**	
Heart CATH	☐ **Yes** ☐ **No**	Do you have metal in your body ☐ **Yes** ☐ **No**	
Pacemaker	☐ **Yes** ☐ **No**	*If yes please explain*	
Implanted Defibrillator	☐ **Yes** ☐ **No**		
CANCER	*Please list ALL types of cancer you have been treated for:*		
FAMILY HEALTH HISTORY	*Do you have a family history of any of the following diseases? Please list which relative is affected (ex: mother, father, sister, brother)*		
		Family Member(s)	
Cancer	☐ **Yes** ☐ **No**		
Glaucoma	☐ **Yes** ☐ **No**		
Retinal disease	☐ **Yes** ☐ **No**		
Diabetes	☐ **Yes** ☐ **No**		
Heart disease	☐ **Yes** ☐ **No**		

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EYE DISEASE *Have you ever had any eye disease?*		If yes, please explain include year diagnosed
Cataracts	☐ **Yes** ☐ **No**	
Corneal disease or transplant	☐ **Yes** ☐ **No**	
Diabetic eye disease	☐ **Yes** ☐ **No**	
Glaucoma	☐ **Yes** ☐ **No**	
Lazy eye (Amblyopia)	☐ **Yes** ☐ **No**	
Macular degeneration	☐ **Yes** ☐ **No**	
Muscle disorder (Crossed eye)	☐ **Yes** ☐ **No**	
Retinal detachment or hole	☐ **Yes** ☐ **No**	
Eye injury	☐ **Yes** ☐ **No**	
Eye Surgery or laser	☐ **Yes** ☐ **No**	
MEDICATION/DRUG ALLERGIES		
☐ **No Known allergies**		Please list reaction
Latex	☐ **Yes** ☐ **No**	
Adhesive Tape	☐ **Yes** ☐ **No**	
Other allergies:		
PHARMACY INFORMATION		
Pharmacy Name		
Address/ Phone#		

MEDICATIONS *Please list all prescriptions and over the counter medications (include birth control, aspirin, herb/vitamins)*		
Medication Name	Dosage (ex: 10mg)	How often taken

If needed, list additional medications and / or allergies on a separate sheet of paper.

_____ _____

Patient Signature Date Completed

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