

PATIENT MEDICAL HISTORY

Patient Name: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____

Primary Care Physician: _____ Physician Phone: _____

Physician's Address: _____
(Street) (City) (State) (Zip)

Reason for today's visit: _____

Date of last eye exam: _____ by Dr. _____ local eye doctor
 out of state doctor

1. Please check any of the following which you have or have had:

- | | | | |
|---|---|---|---|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Cataract | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> TB | <input type="checkbox"/> <input type="checkbox"/> Keloids/Scarring Problems |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Angina Date: _____ | <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> <input type="checkbox"/> History of Strokes Date: _____ | <input type="checkbox"/> <input type="checkbox"/> Colitis/Diverticulitis | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Retinal Detach. | <input type="checkbox"/> <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Bleed or Bruise Easily |
| <input type="checkbox"/> <input type="checkbox"/> Amblyopia | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Anesthesia Complications |
| <input type="checkbox"/> <input type="checkbox"/> Trauma | <input type="checkbox"/> <input type="checkbox"/> Diabetes Year Dx: _____ | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> <input type="checkbox"/> Lung Disease | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> <input type="checkbox"/> Autoimmune Deficiencies | |

2. Please list Surgeries (medical, ocular and/or cosmetic) and Dates:

3. Please list any medications or vitamins taken on a daily basis:

4. Are you allergic to any of the following:

Medications YES NO Which medications: _____
Shellfish YES NO Iodine YES NO Latex YES NO If yes moderate or severe

5. Does your doctor recommend antibiotics prior to surgery/dental work? YES NO

If so, why? _____
Name of antibiotic(s): _____

6. Do you smoke? YES NO If yes, how many packs per day? _____

7. Do you drink alcohol? YES NO If yes, how many drinks per week? _____

8. Please check any of the following which a family member has or has had:

- | | | |
|--|----------------|----------------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Cataracts | _____ (relationship) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Glaucoma | _____ (relationship) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Retina Disease | _____ (relationship) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes | _____ (relationship) |

Patient/Guardian Signature: _____ Date: _____

Tech: _____ Date: _____

Patient Name: _____ Date: _____

UPDATE FORM FOR

PAST MEDICAL HISTORY, PAST SOCIAL HISTORY, MEDICATION, ALLERGY, REVIEW OF SYSTEMS, SOCIAL HISTORY

1. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

2. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

3. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

4. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

5. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

6. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

7. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____
