PATIENT MEDICAL HISTORY

Frantz EyeCare

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

Primary Care Physician: _____Physician Phone: _____

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	
❑	❑	Cataract	❑	❑	Arthritis	❑	❑	Autoimmune Deficiencies	❑	❑	Mitral Valve Prolapse
❑	❑	Glaucoma	❑	❑	Thyroid Disease	❑	❑	High Cholesterol	❑	❑	Heart Attack/Angina Date:_____
❑	❑	Macular Degen.	❑	❑	Blindness	❑	❑	Cancer	❑	❑	History of Strokes Date:_____
❑	❑	Retinal Detach.	❑	❑	Heart Disease	❑	❑	Anemia	❑	❑	Liver Disease/Hepatitis
❑	❑	Amblyopia	❑	❑	Seizures/Convulsions	❑	❑	Bleed or Easily Bruise	❑	❑	Kidney Problems
❑	❑	Dry Eyes	❑	❑	Strabismus	❑	❑	High Blood Pressure	❑	❑	Anesthesia Complications
❑	❑	Refractive Surgery	❑	❑	Diabetes Year Dx: _____	❑	❑	Lung Disease	❑	❑	Other: _____

2. Please list Surgeries (medical, ocular and/or cosmetic) and Dates: (Last 10 Years or eye related)

_____ _____

_____ _____

_____ _____

3. Please be prepared to review any medications or vitamins you take with the technician /physician during your visit today.

4. Are you allergic to any of the following:
   Medications ❑ Yes ❑ No Which Medications: _____
   Shellfish ❑ Yes ❑ No Iodine ❑ Yes ❑ No Latex ❑ Yes ❑ No

5. Does your doctor recommend antibiotics prior to surgery/dental work? ❑ Yes ❑ No

6. Do you smoke? ❑ Yes ❑ No Did you have a influenza vaccination? ❑ Yes ❑ No
   Do you drink alcohol? ❑ Yes ❑ No Did you have a pneumococcal vaccination? ❑ Yes ❑ No

7. Please check any of the following which a family member has or has had:
   Cataracts ❑ Yes ❑ No Relationship: _____
   Glaucoma ❑ Yes ❑ No Relationship: _____
   Retina Disease ❑ Yes ❑ No Relationship: _____

Patient/Guardian Signature: _____ Date_____

Translator ❑ Yes ❑ No