Patient Medical History Form

Please complete this form as accurately and completely as possible. Please print. Thank you.			
Today's Date			
Patient's Name (Last, First, MI)			
Patient's Date of Birth			
Patient's Medical Doctor			
Patient's Occupation			
Patient Height and Weight (voluntary)	feet	inches	pounds

Please list all current medications, including eye drops and non-prescription medications, in the space below.

Please list all allergies to medications or foods, and seasonal allergies, in the space below.

Please list all dates and type of surgery, including eye surgery, in the space below.

Please indicate if you (the patient) or a family member (parent, grandparent, brother, sister) ever had the following conditions.	Patient		Family member	
	Yes	No	Yes	No
01. Ambyopia, crossed or lazy eye?	☐	☐		
02. Cataracts?	☐	☐		
03. Eye infection?	☐	☐		
04. Eye injury?	☐	☐		
05. Glaucoma?	☐	☐	☐	☐
06. Macular degeneration?	☐	☐	☐	☐
07. Cardiovascular problems (high blood pressure, high cholesterol, heart disease, arrhythmia, cancer, etc.)?	☐	☐	☐	☐
08. Endocrine problems (diabetes, high/low thyroid, cancer, etc.)?	☐	☐	☐	☐
09. Neurological problems (stroke, numbness, weakness, headaches, paralysis, seizures, cancer, etc.)?	☐	☐	☐	☐
10. Ear, nose, mouth/throat problems (hearing loss, sinus problems, sore throat, cancer, etc.)?	☐	☐		
11. Gastrointestinal/liver problems (heartburn, abdominal pain, cirrhosis, hepatitis, cancer, etc.)?	☐	☐		
12. Genital/urinal problems (discharge, pain, blood in urine, cancer, etc.)?	☐	☐		
13. Blood or lymph problems (anemia, leukemia, HIV/AIDS, cancer, etc.)?	☐	☐		
14. Skin problems (rashes, excessive dryness, non-healing sores, cancer, etc.)?	☐	☐		
15. Musculoskeletal problems (muscle aches, joint pain, swollen joints, arthritis, cancer, etc.)?	☐	☐		
16. Psychiatric problems (depression, anxiety, etc.)?	☐	☐		
17. Respiratory problems (wheezing, cough, asthma, tuberculosis, bronchitis, cancer, etc.)?	☐	☐		
18. Autoimmune diseases (Lupus, Crohn's disease, etc.)?	☐	☐		
19. Recent fever for more than 10 days, unexpected weight loss or gain, fatigue?	☐	☐		
20. Other conditions not mentioned above?	☐	☐		
21. Do you currently smoke, or have you ever smoked?	☐	☐		

Signature of Patient or Legal Guardian _____