Patient Medical History Form

Please complete this form as accurately	and completely as possible. Please print. Thank ye	ou.			
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				р	ounds
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)			tient	Family r	member
ever had the following conditions.		Yes	No	Yes	No
01. Ambyopia, crossed or lazy eye?			<u> </u>		
02. Cataracts?			<u> </u>		
03. Eye infection?				-	
04. Eye injury?		—	<u> </u>		
05. Glaucoma?		<u> </u>			
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		<u> </u>			
	abdominal pain, cirrhosis, hepatitis, cancer, etc.)?	<u> </u>	<u> </u>		
12. Genital/urinal problems (discharge, pain, blood in urine, cancer, etc.)?					
13. Blood or lymph problems (anemia, leukemia, HIV/AIDS, cancer, etc.)?			<u> </u>		
14. Skin problems (rashes, excessive dryness, non-healing sores, cancer, etc.)?			<u> </u>		
15. Musculoskeletal problems (muscle aches, joint pain, swollen joints, arthritis, cancer, etc.)?			<u> </u>		
16. Psychiatric problems (depression, anxiety, etc.)?					
17. Respiratory problems (wheezing, cough, asthma, tuberculosis, bronchitis, cancer, etc.)?			<u> </u>		
18. Autoimmune diseases (Lupus, Crohn's disease, etc.)?			<u> </u>		
19. Recent fever for more than 10 days, unexpected weight loss or gain, fatigue?			<u> </u>		
20. Other conditions not mentioned above?					
21. Do you currently smoke, or have you ever sn	10ked?				
Signature of Patient or Legal Guardian _					