PATIENT MEDICAL HISTORY

Patient's Name ______________________________
Referred By ______________________________
Family Doctor ______________________________
Allergies ☐ No Known Allergies ☐ Seasonal ______________________________

Ocular History	YES	NO		Ocular Medication
Cataracts	☐	☐		______________
Glaucoma	☐	☐		______________
Cornea Disease	☐	☐		______________
njury	☐	☐		______________
Crossed Eyes	☐	☐		______________
Iritis	☐	☐		______________
Retina Disease	☐	☐		______________
Corneal Transplant	☐	☐	☐ Right ☐ Left	______________
Retina Laser	☐	☐	☐ Right ☐ Left	______________
Yag Laser	☐	☐	☐ Right ☐ Left	______________
Contact Lenses	☐	☐	Type _________	______________

Cataract Surgery Date Right eye ________ Left eye _________ **Past Surgery (# of years)** ______________
Lens Implant ☐ Right ☐ Left ______________
Other: ______________________________

Medical Conditions	YES	NO	Year Diagnosed	Medication
Diabetes	☐	☐	_________	______________
☐ Insulin Dependant	☐ Type II		☐ Diet	______________
Hypertension	☐	☐	_________	______________
Arthritis	☐	☐	_________	______________
Cancer	☐	☐	_________	______________
Respiratory	☐	☐	_________	______________
☐ Emphysema	☐ Asthma		_________	______________
Psychiatric	☐	☐	_________	______________
ENT/Mouth	☐	☐	_________	______________
Cardiovascular	☐	☐	_________	______________
Gastrointestinal	☐	☐	_________	______________
Genitourinary	☐	☐	_________	______________
Musculoskeletal	☐	☐	_________	______________
Neurological	☐	☐	_________	______________
Endocrine	☐	☐	_________	______________
Hematologic/Lymph	☐	☐	_________	______________
Allergic/Immunologic	☐	☐	_________	______________

Family History	YES	NO	Relationship
Glaucoma	☐	☐	__________
Macular Degeneration	☐	☐	__________
Cataract	☐	☐	__________
Diabetes	☐	☐	__________
Hypertension	☐	☐	__________
Stroke	☐	☐	__________
Cancer	☐	☐	__________

Social History	Yes	No	
Do you live alone?	☐	☐	
Do you drink?	☐	☐	_____# per day/month/year
Former drinker?	☐	☐	Date quit __________
Do you smoke?	☐	☐	_____# per day/month/year
Former smoker?	☐	☐	Date quit __________

Occupation: ______________________________

Other general health problems:____________________
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