

Black Hills Regional Eye Institute Medical History Form

Name: _____ Date of Birth: _____

Medical Doctor _____ Eye Doctor _____

Medications - Please list below, make a copy of your list for our records, or list them on the attached medication card

Drug or medical allergies: _____

Please circle any conditions below that you are receiving treatment (or have been treated for in the past) and explain in the column to the right.

Constitutional <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Other	
Eyes <input type="checkbox"/> Cataract <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retina Problems <input type="checkbox"/> Dry Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Cancer <input type="checkbox"/> Eyelid <input type="checkbox"/> Eye Muscle Problems <input type="checkbox"/> Cornea Transplant or Degeneration <input type="checkbox"/> Keratoconus <input type="checkbox"/> Herpes Eye Infection	
Cardiovascular <input type="checkbox"/> Heart Attack <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other	
Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> COPD <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Other	
Gastrointestinal <input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Hernia <input type="checkbox"/> Other	
Integumentary <input type="checkbox"/> Skin Disease or Cancer <input type="checkbox"/> Breast Cancer or Disease <input type="checkbox"/> Sjogren's Disease <input type="checkbox"/> Other	

Please continue on the back side of this form...

Musculo-Skeletal <input type="checkbox"/> Degenerative Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> Other	
Neurological <input type="checkbox"/> Stroke <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Other	
Psychiatric <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety <input type="checkbox"/> Other	
Hematologic/Lymphatic <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding or Blood Disorders <input type="checkbox"/> Leukemia <input type="checkbox"/> Other	
Allergic/Immunologic <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Immune problems <input type="checkbox"/> Other	
Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Hormone Replacement <input type="checkbox"/> Other	
Other	

Does anyone in your family have a history of eye disease (cataracts, glaucoma, macular degeneration, keratoconus, corneal transplant, retinal disease, other)? If so, please list below

Do you smoke? If so, how much: _____ Do you drink alcohol? If so, how much: _____

Do you use recreational drugs? If so, what and how much: _____

Occupation: _____

Are you interested in laser vision correction (LASIK)? Yes No

Patient Signature: _____ Date: _____