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

Medications (Include Aspirin & Supplements)	Dose	Reason

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

Please continue on the back side of this form…

Musculo-Skeletal ❑ Degenerative Arthritis ❑ Rheumatoid Arthritis ❑ Lupus ❑ Cancer ❑ Other	
Neurological ❑ Stroke ❑ Paralysis ❑ Numbness ❑ Epilepsy ❑ Migraines ❑ Dizziness ❑ Other	
Psychiatric ❑ Depression ❑ Schizophrenia ❑ Anxiety ❑ Other	
Hematologic/Lymphatic ❑ Anemia ❑ Bleeding or Blood Disorders ❑ Leukemia ❑ Other	
Allergic/Immunologic ❑ Seasonal Allergies ❑ Immune problems ❑ Other	
Endocrine ❑ Diabetes ❑ Thyroid ❑ Hormone Replacement ❑ Other	
Surgery – Please List Types of Surgery and Dates	

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

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Do you smoke? Yes / No If yes, how much: ____________________

Do you drink alcohol? Yes / No If so, how much:_____________________

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

Occupation: ____

Patient Signature: ____Date: _________________________