Medical History Record

Patient Name:_____Last Eye Exam:_____

Name of primary medical doctor:(first & last name)_____

What pharmacy do you use? _____
Name and Street

Personal Medical Information: Do you have problems with any of these systems? If YES, please check box.

Anxiety	Breast Cancer	Renal Disease	HIV/AIDS	Lung Cancer
Arthritis	Colon Cancer	GERD	High Cholesterol	Lymphoma
Asthma	COPD	Hearing Loss	Hyperthyroidism	Prostate Cancer
Irregular Heartbeat	Coronary Artery	Hepatitis	Hypothyroidism	Radiation Treatment
Bone Marrow Tran	Depression	Hypertension	Leukemia	Seizures
Enlarged Prostate	Diabetes	Stroke	Sleep Apnea	Other_____

Have you ever had any surgeries other than on the eyes? Yes No
If yes, please list _____

Do you have any eye conditions? Yes No
If yes, please list _____

Have you ever had any eye surgeries or injuries? Yes No
If yes, please list _____

Do you take medications? Yes No
If yes, please list names: _____
_____

Do you use any eye drops? Yes No
If yes, please list _____

Are you allergic to any medications? Yes No
If yes, please list _____

Please check Yes or No:
Do you smoke/or use tobacco products? Yes No
Do you drink alcohol? Yes No
Do you use any recreational drugs? Yes No

Do you have a family history of any of the following? If yes, please check box.

Diabetes Heart disease Cancer Other_____

Glaucoma Macular Degen. Retinal Detachment Blindness

Other_____