Your Medical History

Patient name: ____ Date: ________________

(circle where appropriate)	Patient Y	Patient N	Relative Y	Relative N		Patient Y	Patient N	Relative Y	Relative N
Infection / cough / fever in past week					Arthritis - Osteo / Rheum / Juvenile				
Contagious diseases / HIV / AIDS					Sleep Apnea				
Chest Pain / Angina					Asthma / Emphysema / Bronchitis				
Heart Attack / CHF					Tuberculosis / Shortness of Breath				
Weakness / Numbness in arms or legs					Epilepsy / Seizures / Stroke / TIA				
Pacemaker / Defibrulator					Fainting / Headache / Migraines				
Heart Valve Disease / Murmur / Fast Beat					Diabetes / Low Blood Sugar Insulin Dependent x _____ years				
High Blood Pressure					Thyroid Problems - Hyper/Hypo				
Ankle Swelling					Liver Disease / Jaundice / Hepatitis				
Psychiatric Disorder - type:					Kidney Problems / Dialysis				
Anemia / Sickle Cell Anemia					Polio / Paralysis / Meningitis				
Bleeding Problems / Blood Clots					Other Diseases Not Listed				
Back Pain / Sciatica / Slipped Disc					Unusual Reaction to Anesthesia				
Cancer - type:					(Females) Pregnant/Nursing				

Do you Smoke? YES / NO - Packs per day? _______ Per week? _______ Do you live alone? Yes / No

Do you drink alcohol? YES / NO - Drinks per day? _______ Per week? _______

List all **ALLERGIES/DESCRIBE REACTION**: (Include: Tape, Latex, IV Dye and Medications) □***NONE*** ____________

List all **PREVIOUS SURGERIES** (Include dates): □***NONE*** ____

List all **MEDICATIONS / NUTRITIONAL SUPPLEMENTS / HERBS / RECREATIONAL DRUGS** you take (include amounts and how often you take each or attach list) □ **NONE** Do you take Aspirin daily? YES / NO

EMERGENCY Contact: ____ Phone: ____________________

Your Eye History

Have you been diagnosed with any of the following in the past? Please note how long you have been aware of these.

F = father **M** = mother (**P** = paternal **M** = maternal) **S** = sister **B** = brother **GF** = grandfather **GM** = grandmother **U** = uncle **A** = aunt

	Patient Y	Patient N	Relative Y	Relative N	COMMENTS	LIST EYE SURGERIES/DATE
Cataracts						
Retina Disease						
Crossed Eyes						
Iritis or Inflammation of the Eyes						
Cornea Disease						
Glaucoma						
Eye Injury						
Macular Degeneration						
Retinitis Pigmentosa						
Diabetic Retinopathy						
Retinal Deatchment						
Other Eye Problems						

To the best of my knowledge, the above information is accurate and inclusive of my past and present medical history.

Patient's Signature: ____ Date: ________________