Adult Medical History

Name_____ _____ **DOB**_____/____/____

Date of last eye exam____/____/_____

REVIEW OF SYSTEMS	Yes	No	Details
skin			
Ears, nose, throat, mouth			
Lungs, breathing			
Heart, blood vessels			
Stomach, intestines			
Genitals, kidney, bladder			
Bones, joints, muscles			
Neurological (headaches, palsy)			
Blood, lymph nodes			
Endocrine (e.g diabetes, thyroid)			
Allergies, immune system			
Psychiatric			
Other			

HISTORY

List the medications you are currently taking _____

_____

List your past surgeries _____

_____

List any known allergies_____

_____

Do you smoke? Yes no if yes, how many packs per day? _____

Do you drink alcohol? Yes no if yes, how many glasses a week? _____

Do you use other substances? Yes no if yes, what nd how often? _____

FAMILY HISTORY	**Yes**	**No**	**RELATIONSHIP**	**FAMILY HISTORY**	**Yes**	**No**	**RELATIONSHIP**
Keratoconus				Strabismus (crossed eye)			
Amblyopia (lazy eye)				Diabetes			
Blindness				Heart disease/stroke			
Cataracts				High blood pressure			
Glaucoma				Thyroid disease			
Macular degeneration				Cancer			
Retinal disease				Other			

Patient's signature _____ **Date** _____/____/____