

PATIENT MEDICAL HISTORY

Patient Name: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____

Primary Care Physician: _____ Physician Phone: _____

Physician's Address: _____
(Street) (City) (State) (Zip)

Reason for today's visit: _____

Date of last eye exam: _____ by Dr. _____ local eye doctor
 out of state doctor

1. Please check any of the following which you have or have had:

- | Yes | No | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | | TB | | Keloids/Scarring Problems | | Cataract | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack/Angina | Date: _____ | Ulcers | | Cancer | | Glaucoma | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Strokes | Date: _____ | Colitis/Diverticulitis | | Anemia | | Macular | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleed or Bruise Easily | Degeneration |
| Seizures/Convulsions | | Liver Disease/Hepatitis | | Anesthesia Complications | | Retinal | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | Detachment |
| Mitral Valve Prolapse | | Kidney Problems | | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | |
| Diabetes | Year Dx: _____ | Arthritis | | <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trauma | |
| Thyroid Disease | | Joint Replacement | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Lung Disease | | Drug Addiction | | | | | |

2. Please list Surgeries (medical, ocular and/or cosmetic) and Dates:

3. Please list any medications or vitamins taken on a daily basis:

4. Are you allergic to any of the following:

Medications YES NO Which medications: _____
Shellfish YES NO Iodine YES NO Latex YES NO If yes moderate or severe

5. Does your doctor recommend antibiotics prior to surgery/dental work? YES NO

If so, why? _____
Name of antibiotic(s): _____

6. Do you smoke? YES NO If yes, how many packs per day? _____

7. Do you drink alcohol? YES NO If yes, how many drinks per week? _____

8. Please check any of the following which a family member has or has had (indicate relationship):

Cataracts _____ Glaucoma _____ Retina Disease _____ Diabetes _____

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Tech: _____ Date: _____

Patient Name: _____ Date: _____

UPDATE FORM FOR

PAST MEDICAL HISTORY, PAST SOCIAL HISTORY, MEDICATION, ALLERGY, REVIEW OF SYSTEMS, SOCIAL HISTORY

1. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

2. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

3. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

4. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

5. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

6. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____

7. Date reviewed and updated: _____ Changes: YES NO Tech: _____
Changes: _____
