

PATIENT MEDICAL HISTORY

Frantz EyeCare

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

Primary Care Physician: _____ Physician Phone: _____

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"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Deficiencies	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Angina Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degen.	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	History of Strokes Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detach.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Bleed or Easily Bruise	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia Complications
<input type="checkbox"/>	<input type="checkbox"/>	Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Year Dx: _____	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

2. Please list Surgeries (medical, ocular and/or cosmetic) and Dates: (Last 10 Years or eye related)

_____	_____
_____	_____
_____	_____

3. Please be prepared to review any medications or vitamins you take with the technician /physician during your visit today.

4. Are you allergic to any of the following:

Medications ☐ Yes ☐ No Which Medications: _____
Shellfish ☐ Yes ☐ No Iodine ☐ Yes ☐ No Latex ☐ Yes ☐ No

5. Does your doctor recommend antibiotics prior to surgery/dental work? ☐ Yes ☐ No

6. Do you smoke? ☐ Yes ☐ No Did you have a influenza vaccination? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No Did you have a pneumococcal vaccination? ☐ Yes ☐ No

7. Please check any of the following which a family member has or has had:

Cataracts ☐ Yes ☐ No Relationship: _____
Glaucoma ☐ Yes ☐ No Relationship: _____
Retina Disease ☐ Yes ☐ No Relationship: _____

Patient/Guardian Signature: _____ Date: _____

Translator ☐ Yes ☐ No