MEDICAL HISTORY

Name:_____ Date of birth:_____

Tobacco History: Do you use tobacco? *Yes or No* What type of tobacco?_____
How much?_____ How long?_____ Have you quit? *Yes or No* If yes, how long ago?____

Alchohol History: Do you consume alcohol? *Yes or No* What do you drink?_____
How much?_____ How long?_____ Have you quit? *Yes or No* If yes, how long ago?____

REVIEW OF SYSTEMS:

Have you previously had or currently have any of the following conditions? If yes, PLEASE EXPLAIN!

Yes No General (e.g., fatigue, weight loss/gain, difficulty sleeping)_____
Yes No ENMT (e.g., hearing problems, vertigo, ear infections)_____
Yes No Gastrointestinal (e.g., vomiting, nausea, ulcers)_____
Yes No Musculoskeletal (e.g., arthritis, muscle aches)_____
Yes No Respiratory (e.g., asthma, COPD, shortness of breath, TB)_____
Yes No Genitourinary (e.g., difficulty urinating, blood, kidney stones)_____
Yes No Neurological (e.g., headaches, paralysis, numbness, dizziness)_____
Yes No Endocrine (e.g., diabetes, thyroid problems)_____
Yes No Psychiatric (e.g., depression, anxiety, panic attacks)_____
Yes No Hema/Lymph (e.g., blood disease, anemia, hepatitis, high cholesterol)_____
Yes No Cardiovascular (e.g., high/low blood pressure, heart attack)_____
Yes No Skin (e.g., rashes, excessive dryness, masses, cancer)_____
Yes No Other Conditions_____

FAMILY HISTORY: Please list any parent, sibling, or child's history of ocular problems, heart disease, cancer, or diabetes.

_____

Father Deceased / Living: (If Deceased please list cause)_____
Mother Deceased / Living: (If Deceased please list cause) _____

OVER THE COUNTER & PRESCRIPTION MEDICATIONS: Please list all present medications or provide a medication list.

Medication	Dosage	How often	What for

ALLERGIES: Please list ALL allergies and reactions (e.g., hives, problems breathing, rashes)

_____

PAST SURGICAL HISTORY: Please list ALL previous surgeries and dates.

_____

_____

PAST OCULAR HISTORY:

- Please list any previous or current ocular diseases (e.g., cataracts, glaucoma, macular degeneration)
  _____
- Please list any current ocular medications you are taking.
  _____
- Please list any previous ocular surgeries/injuries.
  _____