MEDICAL HISTORY Name _____ Date of Birth _____

SOCIAL HISTORY:

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

Alcohol History: Do you consume alcohol? ❑ Yes ❑ No What do you drink? _____
How much? _____ How Long? _____ Have you quit drinking? ❑ Yes ❑ 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!

- ❑ General (e.g., fatigue, weight loss/gain, difficulty sleeping) _____
- ❑ ENMT (e.g., hearing problems, vertigo, ear infections) _____
- ❑ Gastrointestinal (e.g., vomiting, nausea, ulcers) _____
- ❑ Musculoskeletal (e.g., arthritis, muscle aches) _____
- ❑ Respiratory (e.g., asthma, COPD, shortness of breath, TB) _____
- ❑ Genitourinary (e.g., difficulty urinating, blood, kidney stones) _____
- ❑ Neurological (e.g., headaches, paralysis, numbness, dizziness) _____
- ❑ Endocrine (e.g., diabetes, thyroid problems) _____
- ❑ Psychiatric (e.g., depression, anxiety, panic attacks) _____
- ❑ Hema/Lymph (e.g., blood disease, anemia, hepatitis, high cholesterol) _____
- ❑ Cardiovascular (e.g., high/low blood pressure, heart attack) _____
- ❑ Skin (e.g., rashes, excessive dryness, masses, cancer) _____
- ❑ Other Conditions _____

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

_____

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

Medication Dosage How Often? What for?.

_____

_____

_____

MEDICATION Please list ALL medications you are presently taking - including any over the counter meds.

_____

_____

_____

_____

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

_____

PAST SURGICAL HISTORY: Please list ALL previous surgeries.

_____

_____

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. _____

Clear Form Save Print