MEDICAL HISTORY

Name: _____ Date of birth: _____

Have you previously had or currently have any of the following conditions? If **YES**, please circle or 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 Circle Medical History (ocular problems, heart disease, cancer or diabetes)

FATHER: Deceased / Living _____
MOTHER: Deceased / Living _____
OTHER: _____

MEDICATIONS *including over the counter*	DOSAGE	HOW OFTEN	WHAT FOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES	REACTION	ALLERGIES	REACTION
_____	_____	_____	_____
_____	_____	_____	_____

SURGERIES	DATE	**OCULAR SURGERIES**	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you use tobacco? _____ What type of tobacco? _____ How much? _____
How long? _____ Have you quit? *Yes or No* If yes, date quit? _____

Do you consume alcohol? _____ What do you drink? _____ How much? _____
How long? _____ Have you quit? *Yes or No* If yes, date quit? _____