



PATIENT MEDICAL HISTORY

1. Name: _____ Birth Date: ____ / ____ / ____ / Date: _____
 2. Name of Medical Doctor: _____ Phone: _____
 3. Pharmacy: _____ Phone: _____

PLEASE LIST ALL OF YOUR MEDICATIONS

- Brand Name: _____ Dose: _____ Frequency: _____
 Brand Name: _____ Dose: _____ Frequency: _____
 Brand Name: _____ Dose: _____ Frequency: _____
 Brand Name: _____ Dose: _____ Frequency: _____
 Brand Name: _____ Dose: _____ Frequency: _____
 Brand Name: _____ Dose: _____ Frequency: _____

5. Do you have any drug allergies? Yes No
 Name of Drug(s) _____
 Reaction _____

6. Do you have any Latex allergies? Yes No

7. Do you smoke? Yes No

8. Do you drink? Yes (how much) _____ No

9. Have you ever had a reaction to Anesthesia? Yes No
 If yes, what occurred? _____

10. Do you have a history of Fainting? Yes No

11. Describe any Eye Surgery or Injury you have had (include date and Doctor who treated you)
 _____ Date: _____ Doctor's Name: _____

12. Why are we examining you? _____

CIRCLE ANY BELOW THAT YOU HAVE NOW OR EVER HAD

- | | | | | |
|--|---|---|---|--|
| <input type="radio"/> Alzheimer/Dementia | <input type="radio"/> Bronchitis | <input type="radio"/> Heart Attack or Disease | <input type="radio"/> Kidney Stones | <input type="radio"/> Stroke/Paralysis |
| <input type="radio"/> Anemia | <input type="radio"/> Cancer | <input type="radio"/> Heart Failure | <input type="radio"/> Lymphoma | <input type="radio"/> Type 1-Ins Dep |
| <input type="radio"/> Angina | <input type="radio"/> Convulsive Disorder | <input type="radio"/> Hepatitis | <input type="radio"/> Leukemia | <input type="radio"/> Type 2-Non Ins Dep |
| <input type="radio"/> Anxiety Disorder | <input type="radio"/> Connective Tissue | <input type="radio"/> HIV/AIDS | <input type="radio"/> Nervous Disease | <input type="radio"/> Thyroid Disorder |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Hypertension | <input type="radio"/> Obstructive Pulmonary Disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Asthmas/Hayfever | <input type="radio"/> Ear Disease | <input type="radio"/> Hodgkin's | <input type="radio"/> Pacemaker | |
| <input type="radio"/> Back Problem | <input type="radio"/> Emphysema | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Pneumonia | |
| <input type="radio"/> Bladder Problem | <input type="radio"/> Fracture(s) | <input type="radio"/> Kidney Disease | <input type="radio"/> Sinus Disease | |

Other: _____

14. Does any family member (blood related) have/had a significant Eye disease?
 If YES, who and describe; _____