Medical Information & History

Date_____

Last Name_____First Name_____MI____DOB_____

Date of Last Eye Examination_____Location_____

Personal Eye Information

	Patient		Family		
	YES	NO	YES	NO	Relation
Glaucoma					
Macular Degeneration					
Crossed/Lazy Eye					
Cataracts					
Eye Injury					
Eye Infection					

Eye Surgery? Y N Kind of Surgery?_____ Date_____

Do you wear glasses? Y N Contacts? Y N Kind_____

General Medical Information

	Patient		Family
	YES	NO	YES
Cardiovascular (high blood pressure, cholesterol, heart disease, arrhythmia)?			
Endocrine (diabetes, high/low thyroid, etc)?			
Neurological (stroke, numbness, migraines, paralysis, seizures, etc)?			
Ear, Nose, Mouth/Throat (hearing loss, sinus,sore throat, etc)?			
Gastrointestinal/liver (heartburn, abdominal pain, cirrhosis, hepatitis, etc)?			
Genital/urinary (discharge, pain, blood in urine, etc)?			
Blood or lymph (anemia, leukemia, HIV/AIDS, etc)?			
Skin (rashes, excessive dryness, non-healing sores, etc)?			
Musculoskeletal (muscle aches, swollen joints,arthritis, etc)?			
Psychiatric (depression, anxiety, etc)?			
Respiratory (wheezing, coughing, asthma, tuberculosis, bronchitis, etc)?			
Autoimmune disease (Lupus, Crohn's, Cushing's, etc)?			
Cancer?			

Diabetes Y N Type_____ Date of Diagnosis_____

Medical Allergies:_____