# MEDICAL HISTORY

**Patient name**_____ Date form completed_____

**Allergies to medication and the type of reaction it causes:** _____

_____

**Primary Care doctor:** _____

**Primary eye care provider:**_____

**Medical History:** Check all that apply and write in dates if known

☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Heart Attack
☐ Irregular Heart Beat
☐ High Cholesterol
☐ Asthma
☐ Emphysema
☐ Sleep Apnea
☐ COPD
☐ Diabetes
☐ Cancer (type:_____)
☐ Thyroid under/over active
☐ Graves Disease
☐ Bell's palsy ( right / left )
☐ Seizures
☐ Arthritis
☐ Kidney Disease (type:_____)
☐ Liver Disease (type:_____)
☐ Environmental Allergies
☐ Blood Disorders (type:_____)
☐ Anxiety
☐ Depression
☐ Alzheimer's

**Eye History:**

☐ Cataract
☐ Glaucoma
☐ Retinal Detach
☐ Macular Degen
☐ Diab Retinopathy
☐ Crossed Eye
☐ Lazy Eye
☐ Injury (what, when)

☐ **No Medical Problems**

☐ Other medical problems:_____

_____

**Surgery:** List all Surgeries you have had, including general surgery, eye surgery, facial surgery or any other, including the Year

_____

_____

_____

_____

**Family History:** Check all that Apply ☐ **No Family HX**

☐ Droopy lids ☐ Cancer ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes

☐ Blindness ☐ Unexplained Vision Loss ☐ Heart Disease

**Social History:**

Do you smoke? ☐yes ☐No Alcohol? ☐Yes ☐No Drugs? ☐Yes ☐No

Are you or could you possibly be pregnant? ☐Yes ☐No

**List of your current medications, including over the counter medications:**

_____

_____

_____

_____

_____

_____