Medical History Form

Patient Name: _____ Date: _____

Describe any vision changes, indicating which eye and when they started.

_____

_____

_____

_____

Major Illnesses/Medical Diagnoses *(please circle Y for yes and N for no)*

Y / N Diabetes (type I / type II)
Y / N High Blood Pressure
Y / N Thyroid Disease
Y / N Heart Attack
Y / N Heart Disease
Y / N Stroke
Y / N Sleep Apnea
Y / N Other: _____

Y / N Cancer (type: _____)
Y / N Hepatitis
Y / N HIV+
Y / N Breathing Problems
Y / N Bleeding Problems
Y / N High Cholesterol
Y / N Intestinal Problems

Medications (including eye drops)

Name	Dose	Frequency
Ex: Lisinopril	*Ex: 10 mg*	*Ex: 1 tablet once a day*

Drug Allergies

Allergy	Reaction

Surgeries

_____ _____

_____ _____

_____ _____

Family History *Have any family members had these diseases? If YES, please indicate ONLY: grandfather/grandmother, father/mother, brother/sister, son/daughter*

Macular Degeneration: _____ Glaucoma: _____
Retinal Detachment: _____ Blindness: _____
Heart Disease: _____ Stroke: _____
Diabetes: _____ Kidney Disease: _____
Thyroid Problems: _____ Lung Disease: _____
Cancer: _____ Other: _____

Social History

Marital Status: _____ Occupation: _____
Tobacco Use: _____ Alcohol Use: _____

Preferred Pharmacy

Name: _____

Address: _____

City: _____ State _____

Phone #: (_____) _____ - _____