MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth ___/____/_____ Sex: M☐ F☐

MEDICAL HISTORY: (Do you have the following?)

DIABETES: ..... yes☐ no☐
If yes, for how many years? _____
Highest blood sugar within the past month? _____

Any breathing problem: ..... yes☐ no☐
High blood pressure: ..... yes☐ no☐
HIV: ..... yes☐ no☐
History of cancer: ..... yes☐ no☐ -> If yes, type/date _____
Previous stroke: ..... yes☐ no☐
Do you have any other medical problem(s)? (☐ **NONE**) _____

EYE HISTORY:

Do you have any **eye diseases**? yes☐ no☐
If yes, please provide details: _____
When was your **last eye exam**? _____ ago
Do you use **contact lenses**: ..... yes☐ no☐
Do you wear **glasses**? ..... yes☐ no☐ -> 0 check here if glasses are only for reading
Do you have a **lazy eye**? ..... yes☐ no☐ -> Which eye? Right☐ Left☐ Both☐
Ever been **hit in your eye**? ..... yes☐ no☐ -> Which eye? Right☐ Left☐ Both☐
Have you had **eye surgery** before? ..... yes☐ no☐ -> Which eye? Right☐ Left☐ Both☐
If yes, please provide details and dates below

_____
_____

Have you had laser eye surgery? ..... yes☐ no☐ -> Which eye? Right☐ Left☐ Both☐
If yes, please provide details and dates below:

EYE DROPS: Gist all eye drops you use and how often you use them) ..... ☐ **NONE**

_____
_____

MEDICATIONS (PILLS): (only write down the name, NOT the dose) ..... ☐ **NONE**

_____
_____

ALLERGIES:

Are you **allergic** to any medicine: ..... yes☐ no☐
If yes, please provide name(s) of the medicine(s): .....

FAMILY HISTORY:

Anyone in your family have **glaucoma**? ..... yes☐ no☐ -> If yes, who: _____
Any **eye diseases** that run in your family? .... yes☐ no☐ -> If yes, please explain: _____
Is anyone in your family **cross-eyed**? ..... yes☐ no☐
Anyone in your family **blind**? ..... yes☐ no☐

GENERAL MEDICAL QUESTIONS: (Do you have the following?)

Fever: ..... yes☐ no☐
Frequent Headaches: ..... yes☐ no☐
Are you pregnant: ..... yes☐ no☐
Muscle weakness: ..... yes☐ no☐
Numbness: ..... yes☐ no☐
Rash: ..... yes☐ no☐
Cough: ..... yes☐ no☐
Have you had a heart attack: ... yes☐ no☐
History of Tuberculosis: ..... yes☐ no☐
If yes, when were you treated? _____
Hepatitis C ..... yes☐ no☐

Blood in your stool: ..... yes☐ no☐
Recent weight loss: ..... yes☐ no☐
Recent decreased appetite: ..... yes☐ no☐
Pain when you urinate: ..... yes☐ no☐
Joint pain: ..... yes☐ no☐
Muscle pain: ..... yes☐ no☐
Low back pain: ..... yes☐ no☐
Diarrhea: ..... yes☐ no☐

X _____
SIGNATURE DATE