

# Medical History Form

Name \_\_\_\_\_

Date \_\_\_\_\_

**LIST** any *medical* conditions that you have (e.g., diabetes, high blood pressure, arthritis, etc.):

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**LIST** any *eye* conditions that you have (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment):

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**LIST** any medications that you take:

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**LIST** any drug allergies:

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**Do you have any of the following problems:**

**If yes, please explain**

Chronic fever, unexpected weight gain/loss, fatigue	Y	N	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	Y	N	_____
Heart Problems (e.g., chest pain, irregular heartbeat)	Y	N	_____
Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis)	Y	N	_____
Gastrointestinal problems (e.g., heartburn, diarrhea, abdominal pain)	Y	N	_____
Urinary problems (e.g., pain or discomfort, bladder infections)	Y	N	_____
Skin disease (e.g., rashes, eczema, dermatitis)	Y	N	_____
Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints)	Y	N	_____
Neurologic problems (e.g., numbness, weakness, paralysis, headache)	Y	N	_____
Psychiatric problems (e.g., depression, anxiety)	Y	N	_____

**CIRCLE** any of the following eye conditions that run in your family:

glaucoma

macular degeneration

retinal detachment

**DO YOU:**     Smoke? How much? \_\_\_\_\_     Drink Alcohol? How much? \_\_\_\_\_

Reviewed by Physician    Comments: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_