VANTAGE
EYE CENTER

MEDICAL HISTORY FORM

(PLEASE PRINT)

Name _____ **Date** _____

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

_____

_____

_____

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

_____

_____

_____

LIST any medications that you take:

_____

_____

LIST any drug allergies:

_____

_____

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: _____