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 disease?**……… **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 ☐ → ☐ 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: (list all eye drops you use and how often you use them**)**………… ☐ **NONE**

____ ____
____ ____
____ ____

MEDICATIONS (PILLS):……….... ☐ **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 ☐ → Is anyone in your family **cross-eyed**?.....**yes** ☐ no ☐
If yes, who: _________________________ → Anyone in your family **blind**?..................**yes** ☐ no ☐
Any **eye disease** that runs in your family?........**yes** ☐ no ☐
If yes, please explain:____________________________

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 ☐

Diarrhea: ……………………………… **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 ☐

X ______________________________ ____________
SIGNATURE **DATE**